•	,		State of Maryland /  1- State AMEND ITEM #8 PER INF&29d PER PHY	Depa	artment o	of Head	alth a eath	nd Me	ental Hyg	jiene ,	2004	07001
*	Physici /Medic		Decedent's Name (First, Middle, Last)  CLARA CURRY BURNETT						2. Date of Dea Month FEB • 1	Day 4,20		3. Time of Death 4:48P
*	Examin Funeral		4a. Facility Name (If not institution, give street and number)  9020 BILLINGSLEY ROAD  5. Social Security Number 6. Sex 7. Age (In yrs. last in the second security Number)	birthday)	4b. City, Tov WHI  If Under 1 Y Months D	TE (ear	PLA f Under 2 Hours	TNS	8. Date of Birth		CHARL  1924 Birth	ES place (State or Foreign ntry) I'VIRGINIA
	Director		236-32-1518	Yrs.		ays	Hours	Min.	EC.4,	1919		VIRGINIA
	ath with the Marylar 123s or 28e-f show ust be rediffed at	ector	MARYLAND CHARLES  10e. Street and Number		WHITE		AINS	S		10a. Citize	n of What Cou	1 ☐ Yes 2√ No
	th with	al DI	9020 BILLINGSLEY ROAD			206	95			_	.S.A.	
036	be filed within 72 hours after death with the Maryland stal Hygiene.  do other than "neturel", or items 23s or 28e-f show of other than "neturel", or items 23s or 28e-f show event, the Medical Examinar must be indiffical at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes, Give Ayear or Dates:		Was Decedent If Yes, specify 1 ☐ Yes 2√2		anic Orig Mexican, Specify:	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White pecify: W]	
21215-0036	within 72 ho ene. than "netur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 1 2	(Give life.	dent's Usual O kind of work o DO NOT use n	occupation done duri retired)	on ing most	of workin	g	16b. Kind of Business/Industry		ndustry AL SERVICE
Maryland 2	should be filed wil nd Mental Hygien marked other th umetic event, the	To Be Co	17. Father's Name (First, Middle, Last)  LEANDER CURRY		DDKK	18				Maiden Sumame) BLANKENSHIP		
Mar	2 a a a										Town, State, Zi,	, MD • 20695
Baltimore,			20a. Method of Disposition 20b. Place ceme  XXPurial 2 □ Cremation 3 □ Removal from State	of Dispo	esition (Name of natory or other	of er place)			ate	20c. Loca	ation - City or T	
Balti	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Licensee M00479	$\mathcal{G}$	LA PL	ND ATA	of Facility FUN	, ERAL RYLA	SERV	ICE,		
· ·	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that gaused the death. Description shock, or heart failure. List only one cause on earth fine.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conditions)	CE								Approximate Interval Between Onset and Death
3760,	ate be executed hysicien and he buriat-transit	Ilcal Examiner	Sequentially list conditions, it by, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequenc									
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physionage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death	ath 3	⊒Ectopic pregi ⊒ Other (speci					23	d. Date of deliving	very Day Year
	aw requires that s been signed b s should be deta	þ	Part II. Other significant conditions contributing to death but not resulting	g in the u	indertying caus	se given	in Part I.		23e. Did to			the cause of death?
Il Records,	The law re ate has bee page 2 sho	Completed			<del></del>				24a. Was autop perfor	sy	24b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of 2 No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Outpatie	nt 3□ DOA	Other:			(Check only o		☐Other (Spec	(6c)
Division of	Jing After fune	Certification; To	27. Manner of Death  Natural 5 Pending (Month, Day Year)  28. Date of Injury (Month, Day Year)  28. Date of Injury (Month, Day Year)	b. Time o	of 28c.			No 2	8d. Describe h	low injury	occurred	
Divi	itel or At urs after or ret Direct lled in by	Certifi	4 Homicide determined 28e. Place of Injury - Actionne building, etc. (Specify)			_			City or Tou	m, State)		ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the the	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowler one)  Certifying Physician: To the best of my knowler one	dge, deat and/or in	vestigation, in	my opin	nion, deat	d place, a th occurre	d at the time,	date and p	olace, and due	to the cause(s)
	5 will	~	Agrate no		D	icense r 43	34	6 np-	A 10		signed (Month	, way, 1001)
	1.3		30 Name and address of person who completed cause of death (Item 23	a) (Type,	CLIN CLIN	TON	) n	M)	2073	5		
	St Regist	ate rar	31. Date filed (Month, Day, Year)  AR 0 8 2004	his	de la							

State of Maryland / Department of Health and Mental Hygiene [ ] 07002 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 6:22 M 2004 Agatha Ann Bouchelle 26 - ebruary /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Cecil Elkton 1639 Blue Ball Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Months 1 ☐ M 2 💢 F 84 1919 Maryland Director 221-14-0192 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f ehow r then "natural", or Items 23a or 28a-f ehov the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Maryland Cecil Elkton Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1639 Blue Ball Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Chemical nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill timent of Health and Mental H tant: If them 27 is marked oil jury or other traumatic even Agatha Reed Scott Wilmer Holliday Simpers Bouchelle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Henrietta W. Siebold/Sister 54 Sunset Road, Newark, Delaware 19711 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Head of Christiana
Presbyterian Cemetery 2004 March 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Newark, Delaware 22. Name and Address of Facility Hicks Home for Funerals, P.A. permit. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** Immediate Acuta /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of). physician Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year ŏ Dav 4 Pregnant at time of death signed by the a P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No luneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 Pending 1 X Natural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a, Certifier 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hispital
32. Registrar's Signature 31. Date filed (Month, Day, Year) Union State

DHMH 17 Rev 1/2001

Registrar

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**ORIGINAL** 

			For State	ricasc	State o	f Marylar	nd / Depa	artment rtificate	t of H	ealth a	and M	ental Hyg	iene 2 (	104	07003
			Registrar  1. Decedent's Name (First	t. Middle. La	ist)							2. Date of Deat	h		3. Time of Death
	Physicia	an	Estella E.									Month	rv 11	Year 04	8:19 am
-	/Medic		4a. Facility Name (If not in			nber)		4b. City,	Town, or	Location o	of Death	Februa	4c. County	1	0,15 am
	Examin	er	Atlantic Ge					Re	rlin				Wor	ceste	r
	Euparal		5. Social Security Number	6. 9	Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birthpla	ace (State or Foreign
	Funeral Director		214-32-1839		1□M 2只F	66	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Aug 15,	1937	M	ace (State or Foreign Y) D
	D		Usual Residence of Dece			100 0	ity, Town or L							10	d. Inside City Limits
	show	_		County			•	Jeanon							1 StYes 2 No
	Be-f s	cto		Vorces	ter	Be	erlin	101 70					0 - Oiti41	Mhas Causa	
	ith th	Funeral Director	10e. Street and Number		D.4			10f. Zip	1811			'	0g. Citizen of \		ıy :
	s 23s	ral	11821 Sinepu	ixent		edent Ever in U	19 13	1	-	snanic Ori	ain? (Spe	acify Yes or No-		U.S.	n Indian.
	er de Item	ů	11. Marital Status 1 ☐ Never Married 2	TO Married	Armed Fo	rces?	7.3.	If Yes, spec	cify Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ck, White, e	
36	irs aff	by	3 ☐ Widowed 4 ☐ D		If Yes, Gir Year or D	ve	1	1□Yes :	2 <b>X</b> No	Specify:			Specif	" Blac	k
Õ	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show he Medical Examinar must be mutified at	pe	15. D	ecedent's E	ducation		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	00	16b. Kind of B	usiness/Ind	ustry
215	hin 7.	be	(Specify onl		completed) College (	1-4or 5+)	life.	DO NOT us	se retired	()	OF WORKS	ng .			
₹ 7	d wit	Completed	9					Hou	seke	eper				tel	
STELLA yland 21	al Hygi s other	Be (	17. Father's Name (First,		t)							(First, Middle, I	Maiden Suman	ne)	
a ST	should but and Ment markax	ဥ	Ernest Colli	ns								urgis			
, STELLA Maryland 21215-0036	2 sho and is m		19a. Informant's Name/R									I Route Number			Code)
	and lealth m 27 her tu		William H. E		n, Sr./		Place of Disp			ent k	-	Berlin,	PID Z18		vn. State
BRATTEN Saltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Dispositio 1 🖾 Burial 2 ☐ Crea	mation 3		State	cemetery, cre	matory or o	other plac	1		- 1			m, clate
AT	tmen tant:		`4 □Donation 5 □ 0	-	-	St	. Paul						Berlin	, MD	
BRATTEN Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic avent, the Medical Examinat must be multipled at once.		21. Signature of Funeral	Salaryo Lio	2.66		Í	ewis .	N. W	atson	' Fun	eral Hor	ne		
	402.00		222 Part Enter the dis	ease or cor	nnlications that	caused the dea	ath. Do not er	618 W	est.	C. such as	Sali	sbury, I	4D_2180 est.	1	Approximate Interval Between
			23a. Part1. Enter the dis- shock, or heart failu Immediate Cause (Final	re. List only	y one cause on	each line.	scleo	4:	1	Larce	/	Die	Eurc		Onset and Death
	Pnysician / /Medical	8 8	disease or condition resulting in death)		a	(or as a conse		41E 6	RICA	IDVK	7CW CRI	~ U(3	u ; C	-	YEEL 5 =
	Examiner			•	Due to	(or as a conse	querice or).								
		ē	Sequentially list condition it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ata	b. Due to	(or as a consu	quanca ;f):								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	1	C										
ć	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last		Due to	(or as a conse	quence of):								
760,	te be ysicia te bu	cal		•	d									-	
Box 68	rtifica ng ph as th	Physician/Med	IF FEMALE:												
ŏ	th cer tendii rr use	an/h	23b. Was decedent preg		1 🗆 Live	itcome of pregr birth 2 □Fel	tal death 3	□Ectopic p		,				te of deliver	y Day Year
	e dea he at led fo	sici	in the past 12 month 1 ☐ Yes 2 ☐ No	ns :	4∏Preg 9∏Unkr	nant at time of nown	death 5	Other (sp	oecify)						,
P.0	that the de led by the a detached f	Phy	9 ☐ Unknown  Part II. Other significant	aanditions	eentributing to	looth but not re	eulting in the	underhina	cause div	en in Part I		23e. Did to	bacco use con	tribute to the	e cause of death?
<u>v</u>	Se 19 6	þ	Part II. Other significant	conditions	contributing to c	iea(ii but not ie	soung in the	undenying c	Jause giv	on mir and		1	es 2□No	3 ☐ Proba	V
orc	w require been si should I	sted										040 1460 0	245	Mara sutar	neu findinge quailable
ec	ne law has b	Completed										24a. Was a autops perfor	SV	prior to con death?	osy findings available apletion of cause of
ᇤ	ician: The l certificate ha ector, page											1 ☐ Yes		1 🗆 Yes	2□ No
Vita	ician certif	Be	25. Was case referred to examiner?	medical	Hospital:		¥=====		Oth Oth			h Check onl or	5.5	nas (Canaih	
of	Physician: r this certifica	2	1 Yes 2 No.	_	28a. Date		28b. Time		28c. Injun Wor	4 🗀 INI		me 5 Residence 128d. Describe h			)
no	<b>S E S</b>	ţ	175 Natural 5	Pending investigati	(Moi	nth, Day Year)	Injury	М		k? Yes 2.⊡	No .				
Division of Vital Records,	Attending ir death. ector: After by the fune	fica	0 00.0.00	Could not	be 28e. Plac	e of Injury - At		treet, factor	y, office			28f. Location (S City or Tow		ber or Rurai	Route Number,
<u>S</u>	7 2 2 2	Certification:	4  Homicide	40.0	build	ting, etc. (Spec	city)					City of Tow	ii, Siale)		
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier	Certifying I	Physician: To th aminer: On the	e best of my kr	nowledge, dea	th occurred	at the tir	ne, date ar	nd place,	and due to the c	ause(s) and m	anner as st	ated.
	the Ho hin 24 h the Fu npletely	Medical	(Check only 2 one)	medical Ex	and mai	hasis of examination of the state of the sta	ation and/or				ani occur				
	To the Comp	Σ	29b. Signature and title o	certifier	/	/ .	- (	29	c. Licens	e number	10	2	9d. Date signe	ed (Month, L	Jay, Year)
T			1/1/1/	Ne	udle	ul	1	(	0	101	6/	A	× 11	110	1
			30. Name and address o	f person wh	o completed cau	ise of death (It	<b>\$</b> m 23a) (Type	Print)	l.	20	9 1	Cexes	Tell 1	Herm	0944
2 DEX			Michaeles	/U (	1000	DOWN Registrar's Sign	nature			the	rica (	750	ust,	PCI	,,,,
	Sta Regist	ate rar	31. Date filed (Month, Da	B 12	1	Seperal S 3191	B	St	sack	1					

State Registrar 31. Date filed (Month, Day, Year) FEB 1 2 2004

ANA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NUBIO

32. Registrar's Signature

MD

111 Penn Street, Baltimore, Maryland 21201

Sports

**OCME** 

FEBRUARY 7,2004

State of Maryland / Department of Health and Mental Hygiene 2001 07005 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 12 **Physician** 7:00  $A^{M}$ 2004 Chen **Evelyn** C. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 1 F 96 Sept. 23,1907 China Director 579-32-0172 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene Importants; if item 27 is marked other then "naturel; or iteme 23a or 28e-f show any injury or other traumatic event, the Neulcal Exams set mas the notified any 1 ☐ Yes 2X No Chevy Chase Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20815 5500 Friendship Blvd. #920N Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Asian 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State Dept. / Federal Elementary/Secondary (0-12) College (1-4or 5+) 5+ Translator Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Montgomery Village, MD 20886 9713 Digging Road Raymond F. Chen / Son Feb. 12, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury Germantown, Maryland All Souls Cemetery 2004 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home Gaithersburg, MD 20377 10 E. Deer Park Dr. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adult Failure to Thrive > 1 Year **Physician** /Medical Due to (or as a consequence of): Examiner > 1 Year End Stage Dementia Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and I-transit Due to (or as a consequence of) the attending physician a hed for use as the burial-Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months?
1 ☐ Yes 2 🕅 No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. | detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à should be 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 autopsy performe has certificate 2X No 1 Yes Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled To the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, Maryland 20855 Charles Harrison, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State sacks FEB 1 7 2004 Ryen Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienea on the

			For State Registrar	State of Ma	ıryıana / L	Jepartme <i>Certifica</i>	ent of He ate of D	eaith and M <i>leath</i>	ientai myg	leg No. 2004	07006
	Dhysiei		Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	Day Year	3. Time of Death
	Physicia /Medic		Robert Barron C			45 0	h. Tour and	ocation of Death	Februar	cy 17, 2004	
	Examin	er	4a. Facility Name (If not institution, give		4	40. Ci	01ne				
	Funeral Director		Montgomery Gene 5. Social Security Number 6. Security Number 11 214-28-4371	ral Hospit ex 7. Age MiM 2□F	in yrs. last bir	Yrs. If Uni	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 6	r, Year) C	mery rthplace (State or Foreign country) aryland
Ī	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location			<del> </del>		10d. fnside City Limits
	death with the Maryland ms 23a or 28e-f show rmust be nutified at	to	Maryland Montgon	nerv	Sil	ver Spi	ing				1 ☐ Yes 2 █ No
	or 28e	Directo	10e. Street and Number				Zip Code			10g. Citizen of What C	ountry?
	ath wi	rai	10701 Glenhaven		Turan in 11 C	12 Mac De	209		nodu Voe er No	USA 14. Race - Am	erican Indian
30	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic avent, the Micdical Examiner must be nutilised at once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent 8 Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates:	lo		pecify Cuban pecify No	panic Origin? (Spi , Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	ite, etc.
3	2 hou		15. Decedent's Ed (Specify only highest gra	ucation		Decedent's U	sual Occupat	ion iring most of work	ina	16b. Kind of Business	s/Industry
9500-6121	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO	T use retired)			D 1 m .	
Z	Hygier Hygier ther th		17. Father's Name (First, Middle, Last)	4		Real		Apprais 18. Mother's Name		Real Estat Maiden Sumame)	te/Own Busines
Maryland	ld be lental ked o	To Be		onald Clas	pett			Helen	Barron		
ary	and M s mar	-	19a. Informant's Name/Relationship (7			. Mailing Addr	ess (Street ar	nd Number or Rura	al Route Numbe	r, City or Town, State,	Zip Code)
Ξ,	and 2 ealth a m 27 i		Margaret H. Clage	tt/ Wife					Silve	r Spring.	
nore	ages 1 int of H t: If ites		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Other (Specify		cemete	f Disposition (I ry, crematory o wn Memo	or other place,	Febru	ary 20	20c. Location - City of	
Baitimore,	permit. P Departme Importan Inny injur.		21. Signature of Funeral Service Licen		1 alkie	Franc:	and Address	of Facility Collins	Funera1	Home Inc.	, Maryland
26			23a. Part1. Enter the disease, or form shock, or heart failure. List only	olications the caused	the death. Do	not enter the n	nivers.	such as cardiac	or respiratory ar	rest,	Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition	sne cause on each in							Onset and Death
	/Medical		resulting in death)	d	a consequence	of):					
	Examiner	1	Sequentially list conditions,		y Arter		ase				
	nted Insit	Examiner	Sequentially list conditions, if any, leading to incuediate cause. Enter Underlying Cause (Disease or injury		cular Ta		dia				
oʻ	ificate be executed g physician and as the burial-transit	Exal	that initiated events resulting in death) Last	V.	a consequence						
98760	ate be physici the bu	edicai		d							
O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ⊟Ectopii 5 □ Other	c pregnancy (specify)			23d. Date of de Month	elivery Day Year
1	ires that the signed by	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting i	in the underlyin	ig cause giver	n in Part I.		obacco use contribute l'es 2 □ No 3 ⊡ F	to the cause of death?  Probably 4 □Unknown
200	w require been si should	ietec							24a. Was		utopsy findings available
Vital Records,	The law	Completed							autop perfor 1  Yes	rmed? prior to death?	completion of cause of
ital		BeC	25. Was case referred to medical examiner?					26. Place of Deat			
o t <	Physic this ce	은	1 ☐ Yes 2 🖾 No	Hospital: 1 ☑ Inpatie			DOA Other	4 🗆 Nursing no		lence 6 Other (Sp.	ecify)
U <sub>O</sub>	ding P. h. After I	tlon:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injui (Month, Da)		Time of fnjury M	28c. Injury Work?	at es 2 No	28d. Describe n	now injury occurred	
Division	Atten er deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined						28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	To the Hospitel or within 24 hours afte fo the Funerel Dir completely filled in	edical C			examination ar					cause(s) and manner a date and place, and du	
	To the route of the complex co	Med	29b. Signature and title of certifier	1			29c. License	number		29d. Date signed (Mor	nth, Day, Year)
1	~1		> /ht	14	and		Ī	>54269		February	18, 2004
1	V		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Print)					
	- 0		Matthew J. Connol: 31. Date filed (Month, Day, Year)	Ly M.D 32. Begistra	18109 ar's Signature	1	/	=	#225 <b>,</b> 01	Lney, MD 20	0832
	Sta Regist		FFB 2.0.20		var k	9 1	racks	/			

		1 - For State Registrar	State of Maryland / Do	epartment o	of Health and of Death		ene2 () () L	07007			
		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
Physici /Medic		Suzanne Thompso	on Conley			Month February	14, 2004	12:15 P M			
Examin		4a. Facility Name (If not institution, give sa		4b. Cîty, Tov	vn, or Location of Deat		4c. County of Deat				
		3000 Arbor Square	Drive	Fred	erick		Frederi	ck			
Funeral		Social Security Number     6. Sex	7. Age (In yrs. last birth	Months D	ear If Under 24 Hrs ays Hours Min.	(Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)			
Director		212-38-3/19	96	rs.		Jan. 27,	1908 Pe	nnsylvania			
and and		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
f ehc	ō	Maryland Frederic	le Emodo					1 ☐ Yes 2 🛣 No			
the 28a-	ect	10e. Street and Number	k Frede	10f. Zip Co	de	100	. Citizen of What Co	untry?			
with 3a or	Funeral Director	2000 Ambon Square	Danders			109		orti y i			
heath ris 2:	era	3000 Arbor Square	2. Was Decedent Ever in U.S.		21701 of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ame	rican Indian.			
r Itar	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🙀 No		of Hispanic Origin? (S Cuban, Mexican, Puer	o Rican, etc.)	Black, White				
ours a	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔯	No Specify:		Specify: Whi	te			
72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. D	Decedent's Usual O	ccupation	rtina 16	b. Kind of Business/	Industry			
ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		one during most of wor etired)	l L	ontgomery	County			
ed wi	Co		2 Ac	lministra	tive Assis	tant I	Public Sch				
d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)				
Men Men arke	၉	Samuel Thompson				e Burger					
2 sh and le m		19a. Informant's Name/Relationship (Typ	ne, Print) 19b. N	Mailing Address (St	reet and Number or Ru	ıral Route Number, C	City or Town, State, 2	(ip Code)			
and lealth m 27 har tr		Sidney M. Conl						VA 22201			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 ie marked other then "naturel", or items 23a or 28a-f ehow empty injux goother traumatic event, the Medical Examinar must be notified at ance.		20a. Method of Disposition  1 Burial 2 Cremation 3 Re	cemetery,	Disposition (Name of crematory or other	place) Febru	uary 17	c. Location - City or	Town, State			
men tant: jury		*4 □ Donation 5 🖾 Other (Specify)	Cen	of Heaven metery		2004 Si	lver Spri	ng, Maryland			
Depart Import eny in		21. Signature of Juneral Service License	00	22. Name and A	ddress of Facility J. Collins						
007 e a		monen of	Well	500 Univ	ersity Blv	d. W., Si	lver Spri	ng, MD 20901			
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do no cause on each line.	t enter the mode of	dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	Congestive Heart	Failure				Onset and Death  1 month			
/Medical		resulting in death)	Due to (or as a consequence of)								
Examiner		Sequentially list conditions, b.									
D #	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)	:							
be executed sicien and burial-transit	Examin	Cause (Disease or Injury that initiated events c									
e ex	ω ω	Substitution of the substi									
ate b hysic the b	dlcal	d.									
The law requires that the death certificate be executed tile has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Mec	IF FEMALE:									
ath c ttend or us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	tc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregn	ancy		23d. Date of deli	very Day Year			
at the dea by the a tached f	/sic	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify	y)		Mortu	Day 18a1			
that the ed by detacl	Ph,										
res ti	þ	Part II. Other significant conditions cont Hypertension	nouting to death but not resulting in ti	ne underlying cause	e given in Part I.		co use contribute to				
w require been si should I	Completed					1 Yes	2⊠No 3∏Pro	obably 4 Unknown			
law lasb	nple	Hyperlipidemia				24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of			
	Son					performe 1 ☐ Yes 2 🗵	d? death?	2□ No			
Physician: r this certific ral director,	Be (	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)					
Physic this co	2	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Outp	atient 3 DOA	Other: 4 Nursing H	ome 5 🔀 Residenc	e 6 Other (Spec	ity)			
D 0 0		27. Manner of Death t 反Natural 5 ☐ Pending	28a. Date of Injury 28b. Tin (Month, Day Year) Inju	ne of 28c. I	Injury at Work?	28d. Describe how	injury occurred				
eath. or: A	catl	2 Accident investigation			1 ☐ Yes 2 ☐ No						
il or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, off	ice	28f. Location (Stree City or Town, S	t and Number or Ru. State)	ral Route Number,			
urs al											
e Hospital or Al 124 hours after of Funerel Directletely filled in by	edical	29a. Certifier 11√ Certifying Physi (Check only one) 2 Medical Examino	cian: To the best of my knowledge, our on the basis of examination and/o	death occurred at the princestigation, in r	e time, date and place ny opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
To the Hospital of within 24 hours at To the Funerel D completely filled in	Mec	29b. Signature and title of certifier	and manner stated.	29c. Lio	cense number	29d.	Date signed (Month	, Day, Year)			
		husten	LAN MAD	T	31839						
6		30. Name and address of person who com	Inpleted cause of death /Itom 2251 CT		51033	F	ebruary 1	0, 2004			
					omery Aven	ue. Rockwi	111e. MD	20850			
		CILL SCOPIEL DUII	TOTA III-D. OID ME	our mones	January Livell	,	, 1117	40000			

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2004

State of Maryland / Department of Health and Mental Hygiene?  $\bigcap$   $\bigcap$   $\bigsqcup$ 07008

					C	ertificate (	of Death		Reg. No.	UT	07000
		1. Decedent's Name (First, Mi	ddle, Last)					2. Date of Month	Death Dev	Year	3. Time of Death
	Physician /Medical	CERITA		CORN	FIELD			FEBRUA			4:15 PM
	Examiner	4e Fecility Name (If not institu	tion, give street an	nd number)			4b. City, Tox	wn, or Location of De	ath 4c. County	of Deeth	
		LAYHILL NURSIN	IG HOME					SPRING	MONTGO		
	Funeral	5. Social Security Number	6. Sex	7. Age (In yr.		Months D	ear If Under a	Min. (Month,	Day, Year)	9. Birthr	plece (State or Foreign ntry)
н	Director	200-01-9255	1 □ M 2)X	11	35 Yrs.			OCT.	5, 1918	PENN	ISYLVANIA
	pu &	Usuel Residence of Decedent  10a, State 10b, Cou		10c. (	ity. Town or	Location				1	10d. Inside City Limits
	shor shor										1 ☐ Yes 2 ☒ No
	vith the Mar t or 28a-f s be notified Director	MARYLAND MONTO	OMERY		LVER S	10f. Zip Co	de		10g. Citizen of	Whet Cour	ntry?
	with with	Toa. Street end Number		<b>!! == 0.4</b>							, .
	r Herrs 23s river must Funeral	15101 INTERLAC		#524 Decedent Ever in	U.S. 13	20906 Was Decedent		gin? (Specify Yes or	U.S.A.		can Indian,
_	Par In	1 Never Married 2 □ N	Arme	ed Forces? Yes 2 X No	,,,,	If Yes, specify	Cuban, Mexican	, Puerto Rican, etc.)	Bla	ck, White,	etc.
20			If Ye	s, Give or Detes:		1 ☐ Yes 2 🔯	No Specify:		Specify	N: M	WHITE
ĕ	ed within 72 hours a ygiene.  Ner than "natural", of the Medical Engl.  Completed by	15. Dece	dent's Education	201.0	16a. Dec	edent's Usual O	ccupation		16b. Kind of B	usiness/In	dustry
215	nin 7	(Specify only high Elementary/Secondary (0-1	thest grade comple	eted) ege (1-4or 5+)	(Gr.	re kind of work d DO NOT use re	one auring most etired)	or working			
21	d with	12	-, -	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CLER	K			OPTICAL	.a	
p	be filed tother svent, to Be Co		fle, Last)				18. Mothe	r's Name (First, Mide	dle, Maiden Suman	ne)	
<u>la</u>	should be and Mentel a marked o numatic eve		C	ORNFIELD			MARY		ROB	INSON	
an	2 sho end N is ma	19a. Informant's Name/Relati	onship <i>(Type, Print</i>	)	19b. Ma	iling Address (St	reet and Numbe	er or Rural Route Nur	nber, City or Town,	State, Zip	code)20906
Σ	1 and 2 Health am 27 is	HYLA-RUTH NEAM	AN/SISTE	R	1510	1 INTERI	ACHEN D	RIVE #524	, SILVER	SPRI	NG, MD
ore	of Healitam itam	20a. Method of Disposition 1   ☐ Burial 2 ☐ Crematic	a Domewali	[	Place of Dis	position (Name or rematory or other	of r place)	Date	20c. Location	City or To	own, State
Baltimore, Maryland 21215-0020	Pages nent of I	4 Donation 5 Other		JU	DEAN M	EMORIAL	GARDENS	2/16/04	OLNEY, N	MARYL	AND
alti	# # # # # # # # # # # # # # # # # # #	21. Signature of Funeral Serv	ice Licensee	c		22. Name and A	ddress of Facility		AT CHADET	C T	NC
m	Per impo	1 / Injanda	Klido	(MYII)	1			IKE, ROCK			
		23a. Part1. Enter the diseese shock, or heart failure.	or complications	that caused the de	ath. Do not e	nter the mode of	dying, such as	cardiac or respirator	y arrest,	1177	Approximate Interval Between
1	Physician	snock, or near failure.	list only one cause	on eagen line.						1	Onset and Death
· A	/Medical	Immediate Cause (Final disease or condition		De	mer	Tia					ELL LOOM 18
	Examiner	resulting in death)	е	Due to	(or as e cons	equence of):					The grant of
	D # 2		<b>—</b> b							i	
	The law requires that the death certificate be assected at has been signed by the ettending physician end page 2 should be detached for use as tha burial-trensit.	Sequentially list conditions,		Due to	(or es e cons	equence of):					
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68760,	ficate be physicials that bu	that initiated events resulting in death) Last		Due to	or as e conse	equence of):				İ	
9 X	ding se as		d								
Box	to the death certificate by the ettending plateched for use as the Physician/Mec							l set s	Ida-bassa sa		- Marana of death 2
P.O.	y the ched	Part II. Other significant cond	ittions contributing	to death but not re	suiting in the	uncernying caus	e given in Pert I.		□ Yes 2X No	3 □ Pro	o the cause of death?
	v requires that the de been signed by the should be detached leted by Physi							'	LI 100 Jacino	00	<b>223.</b> ,
rds	n sig								as an autopsy		ere autopsy findings vailable prior to
ဝ္ပ	short							pe	erformed?	CO	ompletion of cause death?
Re	The law require sata has been signage 2 should Completed							11	Yes 2KNo	- 1[	□Yes 2□No
tai			ical		_		26. Place	of Death (Check on	()	1	
of Vital Records,	Physician: this certific ral director,	examiner? 1 ☐ Yes 2 No	Hospital:	1 ☐ Inpatient 2	☐ ER/Outpati	ent 3 DOA	Othor: -	rsing Home 5 🗆 Re		ier (Specil	fy)
0	erthi		28a. I	Date of Injury (Month, Dey Year)	28b. Time Injury	of 28c.	Injury at Work?	28d. Describ	e how injury occur	red	
Ö	Attanding or death.  •ctor: After by the fune iffication	1 Deviatural 5 Per 2 Accident inve	estigation	(INGINE)	11,10.7	М	1  Yes 2 □ I	No			
Division	or Attanding lefter death. Director: After in by the fune	3 ☐ Suicide 6 ☐ Cor 4 ☐ Homicide det	ald not be ermined 28e.	Plece of Injury - At building, etc. (Spec	home, farm, s	street, factory, of	fice	28f. Location City or	n (Street and Numb Town, State)	er or Rure	el Route Number,
Ö	tal or Attanding P rs efter death. al Director: After t led in by the funera Certification:										
	To the Hospital or Attanding Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only 2 Medi	cal Examiner: On	the basis of examir	nowledge, dea	ath occurred at the investigation, in a	ne time, date and my opinion, deat	d place, and due to to th occurred at the tim	he ceuse(s) end ma ne, date and place,	anner as s and due t	iteted. o the cause(s)
	thin 2 the full makes	29b. Signature and title of cer		menner stated.		29c. 1 i	cense number		29d. Date signe	d (Month.	Dey, Year)
	7.¥50	255. Oignaturoland title of cel	00.		X A 1 :			<u> </u>	0 0		
	•	and Name		10-9/1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	) d	2000		1 ~~	~ ×	20850
		30. Name end address of pers	CVI) H	RATT	яп ∠за) (тур Д Д	40/ (	researce	ch BLUI	D Surla	33.	2004 20850 Rockiell
	State	31. Dete filed (Month, Day, Ye	nar)	32. Registrer's Sign	nature /	701			2	250	
	Registrar	FEB 1	7 2004	Greva	B	spour	1				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:52 A M February 10, 2004 Helen Crosby /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2₽F 211-05-2112 102 March 4, 1901 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "netural", or Items 23e or 28a-f ehow the Medical Examinar must be notified at 1 XYes 2 No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 15 Casino St. 20906 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: If Itam 27 is marked other than "netural", or ite injury or other traumatic event, the Medical Examples. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: SpecifyBlack δ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joel Anderson Elizabeth E. Beech 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Casino St. Silver Spring, MD 20906 Elizabeth Gillis-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date permit. Page Department important: If 4 □Donation 5 □ Other (Specify) 2/16/2004 Rockville, MD Parklawn Cemeterv 22. Name and Address of Facility Hines-Rinaldi F.H. 21. Signature of Funeral Service Licensee Muan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 New Hampshire Ave. Silver Spring, MD 20904 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis Acute Peritonitis /Medical Due to (or as a consequence of) Examiner Perforated Viscus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 24 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 2 No page 2 s certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို SIL 28a. Date of Injury (Month, Day Year) Director: After the 27. Manner of Death 1 ANatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-11-04 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta MD 4701 Randolph Rd. #203 Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB17 sacks! Registrar

9. Birthplace (State or Foreign Country) Virginia

U.S.A.

Specify: Black

Home

Race - American Indian, Black, White, etc.

10d. Inside City Limits

Yes 2 No

6 months

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 Yes

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State
RegistraMEND#23aI+IIperMD2/20/04, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13, 6:30 AM 2004 4c. County of Deeth

State Registrar

Ravi Passi, M.D.

8609 Second Ave., Silver Spring, MD 20906

Deceder's Name (First, Medical assessment (First, Medical assessment)   Deceder's Name (First (Medical assess	1518	1 - State Benistrar Unnend Ttem#23a	State of Maryland / i					04 0701
## A Facility Numer (if not instance) per some and number)    S. MARY S. MARY S. HOSPITAL		1. Decedent's Name (First, Middle, Last)  James Anthor				2. Date of Death Month	h Day	
Social Security Number   3 Sec.   3 Sec.   1 Sec.   1 Sec.   3 Sec		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o			4c. County o	Death
The part of the pa		158-68-5983 1d	M 20 E	rthday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Aug. 29		9. Birthplace (State or Fore Country) California
Tr. Father's Name (First, Middle, Madden Summane)  17. Father's Name (First, Middle, Madden Summane)  18. Mother's Name (First, Middle, Madden Summane)  18. R. Ross Camardella  19. Life Cushing  R. Ross Camardella  19. Lif	Maryland fabow	10a. State 10b. County					-	10d. Inside City Lim 1 ☐ Yes 2▼
17. Faboris Name (First, Middle, Madden Summane)   18. Mother's Name (First, Middle, Madden Summane)   19. Mother's Name	with the ror 28a-	10e. Street and Number			20607	10		nat Country?
17. Faboris Name (First, Middle, Madden Summane)   18. Mother's Name (First, Middle, Madden Summane)   19. Mother's Name	s after death v	13304 JOHN Dal	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	White, etc.
Physician Medical Examiner.    Physician Medical Examiner   23a Part   Enter the disease, or complications that caused the "eath. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List only one cause on each line.   Appropriate shock or heart failure. List on	within 72 hour then "natural the Medical Ex	15. Decedent's Educ (Specify only highest grade	ation 16a	(Give kind of work done life. DO NOT use retire	during most of wor d)	king	Offsho	ore Marine
Pity sicilar Medical Examiner.    Pity sicilar Medical Examiner.	Mental Hygie arked other attc event, II	17. Father's Name (First, Middle, Last)  R. Ross Camard			18. Mother's Nam	ne (First, Middle, M en Cush:	ing	
23a. Part. Enter the disease, or complications that caused the "eath. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respiratory arrest.  Appropriate the mode of dying, such as cardiac or respirat	nd 2 sho alth and 27 is m r traum			-				
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20. Part is there has diseases, or complications that caused the "eath. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate and the provided as the control of the provided as the control of the provided as the control of the provided as	permit. Pa Departme Important any injury 20058.		- 7	22. Name and Addre	ess of Facility ]	Beall Fu	neral	Home
FEBRUARY 29, 20	/Medical Examiner টু	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute Alcohol Into  Due to (or as a consequence  Due to (or as a consequence	xication of):	ng, stori da carollac	or respiratory and		Approximate interval Between Onset and Death
autiopsy death?    1	sath certificate be attending physicial for use as the bur attending hysicial for use as the bur attending the state of th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	1 ☐ Live birth 2 ☐ Fetal déath 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Mont	h Day Year
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  16. Yes 2 No  16. Yes 2 No  16. Yes 2 No  16. Place of Death (Check only one)  16. Yes 2 No  16. Place of Death (Check only one)  16. Yes 2 No  16. Place of Death (Check only one)  28d. Describe how injury occurred work?  16. Place of Death (Check only one)  28d. Describe how injury occurred work?  16. Place of Death (Check only one)  16. Place of Death (Check only one)  16. Place of Death (Check only one)  28d. Describe how injury occurred work?  16. Place of Death (Check only one)  16. Place of Death (Check only one)  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred work?  28d. Describe how injury occurred  16. Place of Death (Check only one)  28d. Describe how injury occurred  16. Place of Death (Check only one)  28d. Describe how injury occurred  28d. Describe how injury	The lay ate has page 2					24a. Was ar autops perform	n 24b. W y pr ned? de	ere autopsy findings availa or to completion of cause ath?
Second Part	thysician this certifual director	25. Was case referred to medical examiner? 1	I D Inpatient 2 DERVO	utpatient 3 - DOA	her: 4 🗆 Nursing H	lome 5 Reside	nce 6 Other	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as the difference of the cause of the c	After fune	27. Manner or Death  1 Natural 5 Pending  2 Accident Investigation  3 Suicide SacCould not be	four(1) onth, Day Year) 2/29/04 unl 28e. Place of Injury - At home, f	known M 1		unknown 28f. Location (St	reet and Numbe	
OCME FEBRUARY 29, 20	ospital or A hours after hours after meral Dire y filled in b	4 Homicide determined	found in dwelling	ne death occurred at the ti	me, date and place	and due to the ca	den Beach	Maryland
OCME FEBRUARY 29, 20	thin 24 thin 24 the Fu impleted	one) X	ion. On the basis of examination a	noor investigation, in my	opinion, death occu	THOU ALL THE THIRD, US	ate arto piace, ar	id due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To T	Signature and time of certifier	. m.D	230. 110011			-	
State 31 Date filed (Month, Day, Year) 32 Registrar's Signature 32 Registrar's Signature		LING LI	M.T 111 P		Baltimor	e, Marvla	and 2120	1

DHMH 17 Rev 1/2001

ORIGINAL

•				State of Mary						
t			For Amend Items 25,27, State Registrar	zea-i per Mr,	Ce	rtificate of	Death	F	leg. No.	4 0/012
	Physicia	,	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yea	
	/Medica			rellin		4h Cib. Taum	or Location of Death	Januar	y 1 2004 4c. County of De	
	Examine	r	4a. Facility Name (If not institution, give si	treet and number)		_			Prince G	
e-	Funeral		3012 Spark Lane  5. Social Security Number 6. Sex		yrs. last birthday	If Under 1 Yea		8. Date of Birt	9.6	Birthplace (State or Foreign Country)
40	Director		488-01-3615	м 2ДТ	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 2	,1917 M	issouri
	p ,		Usuel Residence of Decedent  10a, State 10b, County	100	c. City, Town or L	ocation				10d. Inside City Limits
	shov shov	5			•	oodiioii				1 ∰Yes 2 □ No
	28a-i	ec	MD Prince Ge	orge's	Bowie	10f. Zip Code			10g. Citizen of What	Country?
	3a or	by Funeral Director	3012 Spark Lane				20715		US	A
	deati	ner		2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian,
98	or ite	Z	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐ Yes 2 🖺 No If Yes, Give		1 Yes 2 No		, , , , , , , , , , , , , , , , , , , ,		White
Ö	72 hours after death with the Maryland natural, or items 23e or 28e f show size Example of the control of the c	9 0	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occi	upation	3	16b. Kind of Busine	
15	n na n na Mudic	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retir	upation e during most of work ed)	ing	TOD: THIS OF DUCKTO	34
212	d within giene.	Completed	12	College (1-401 5+)	Off	ice Mana	iger		American	Lung Assoc.
pu	be filed tal Hygid d other event, il	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
<u>ya</u>	2 should be filed with and Mental Hygiene. Is marked other the sumatic event, Inc.	္	Edward Robert Sto				Anna Ce			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type Melberne Mansfield			ing Address <i>(Stree</i> 2 Spark I		a <i>i H</i> oure Numbe ie, MD.	r, City or Town, State 20715	i, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, Ite Modical Exacultar Livial by notified at DDCs.	4	20a. Method of Disposition	2	Ob. Place of Diso		1	Date	20c. Location - City	or Town, State
ē	Pages nent of I int: # its		1 ☐ Burial 2 X Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State				-2004	Alexandria	VA.
a t	permit. Departm Importa any inju		21. Signature of Funeral Service Litense			2. Name and Add		_	neral Home	•
ω_	Per Imp Per		- Chuan f	ouell			Crain Hwy.			15
	#6		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the e cause on each line.	death. Do not er	ter the mode of dy	ring, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Multi-		arct	Dement	A		4 years
	Examiner			Due to (or as a co	nsequence of):	21		11		
16 g		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):				XAMINER	-
1	be executed sician and burial-transit	Examiner	that initiated events C.				CERTIFICATION APPRI	- DUMEDICAL		
H0.			resulting in death) Last	Due to (or as a co	nsequence of):		APPRO	NED		
687	physic the p	dica	d.				CERTIFICATIO			
No X	leath certificate attending physical for use as the total attending physical for use as the total attending to the	/Me	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of p	regnancy				23d. Date of	delivery
B	death a atter d for u	clar	in the past 12 months?  1  Yes 2  No	1 Live birth 2 □ 4 □ Pregnant at time		⊒Ectopic pregnan ⊒ Other (specify)	су		Month	Day Year
O.	that the death	hys	9 🗆 Unknown	9□ Unknown						
s,	Phyaician: The taw requires that the death certificate this certificate has been signed by the attending physral director, page 2 should be detached for use as the	Completed by Physician/Medical	Part II. Other significent conditions conf	tributing to death but no	ot resulting in the	underlying cause g	liven in Part I.		\	to the cause of death?
ord	een s	ted	Hip Nicoto	//				1 🗆 Y		Probably 4 Unknown
ec	e law has b	du l	ATRIAL MORI	llation			-	24a. Was autop perfor	an 24b. Were sy prior t mod? death	autopsy findings available o completion of cause of
<u>a</u>	ician: The L certificate ha		or W					1 ☐ Yes	2 <b>□</b> No 1□Y	es 20 No
ž	yaician: is certific director.	o Be	25. Was case referred to medical examiner?  1X Yes 22100	ospital:	2 ☐ ER/Outpatie	at 317 DOA 0	ther: 4 Nursing H		ne) ence 6 □Other(S	nacifu)
Division of Vital Records,	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye					ow injury occurred	
io	Attending r death.  ctor: After by the funer	atlo	2 Accident 5 Pending investigation	Nov. 28,2003		4.4	Yes 2 No	Subject	fell	
. <u>ĕ</u>	or Attuation de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, s	reet, factory, office	Ð	28f. Location (S	Street and Number or in, State) Lane, Bowie	Rural Route Number,
	Hospital of hours at Funeral Ditely filled i	ပိ	20a Carifics Phys	Residence	v kaoviodao dos	the constraint at the				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier Certifying Phys (Check only one)	ician: To the best of mer: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	opinion, death occur	red at the time,	ause(s) and manner date and place, and d	ue to the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	1 -		29c. Licei	nse number		29d. Date signed (Mo	onth, Day, Year)
			Much /	tellat	In the	> 500	52089		1/2/04	
			30. Name and address of person who con		(Item 23a) (Type	, Print)	21 0,		//	
			31. Date filed (Month, Day, Year)	A. Registrar's	10 / BRA	voekni	IL BIVE	7 # 376	GAMBRI	115 (12)
	Stat Registra	_	MAD 0 4 2004	Flan Sept 1	IF SO	3000	1 -			21031

			1 - For State Registrar	State of Maryland	/ Depart		lealth and I	Reg	_	4 07013
•	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Las PCFC Last Last Last Last Last Last Last Last	Street and number)	4	Salisbu	or Location of Deatl  CTY  If Under 24 Hrs.		Day Yea (S ZCO) 4c. County of Do Wicomi	eathCO
- [	Funeral Director		5. Social Security Number 6. Se ZIY-16 - YZ06 13 Usual Residence of Decedent	7. Age (In yrs. las		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y February 19	(ear) 9. E 9,1909 1	Birthplace (State or Foreig Country) Jirginia
death with the Maryland	or 28a-f ahow Le notified at	Funeral Director	10a. State 10b. County  Maryland Wicomi  10e. Street and Number		Town or Local	CY 10f. Zip Code		10ç	, Citizen of What	10d. Inside City Limits 1 □XYes 2 □ No Country?
10	rel', or Itams 23s Examiner musi	b	311A Union Ave.  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Army			Lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA  14. Race - Al Black, W  Specify:	merican Indian, Thite, etc. White
ad within	/giene. ar than "natur t, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deceden (Give kin life. DO Mecha		ation during most of wor d)		b. Kind of Busine:	
ould be	and Mental Hygi is marked other numatic event, I	To Be (	17. Father's Name (First, Middle, Last)  Robert Collins  19a. Informant's Name/Relationship (T	voe. Print)	19b Mailing	Address (Street	Jency	Prescott ral Route Number, C		a Zin Codel
, <u>p</u>	nent of Health ant: if item 27 ury or othar tr		Debbie Bassett/Fr  20a. Method of Disposition  1 D Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,	iend  Removal from State 20b. Placent Cent 1st	311A ce of Dispositi netery, cremat Baptis	Union A on (Name of ory or other place t Cemete	ery 2/1	isbury, M Date 20	21801 c. Location - City	
Ph /ľ	ysician Medical		23d. Parl 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each! e. a. Dysto (or as a conseque)	Do not enter t	T DITOM	HITTI KG.	, parraph	Y, MD Z.	ASSOCIATION 1804 Approximate Interval Between Onset and Death
te be executed	physician and stransit transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse or injury that initiated events resulting in death) Last	Due to (or as a consequent						
The law requires that the death certifical	ed by the attending phi detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc  1  Live birth 2  Fetal de  4  Pregnant at time of deat	eath 3 ☐Ec	topic pregnancy			23d. Date of d Month	delivery Day Year
equires that	De d	þ	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the unde	erlying cause give	en in Part I.		co use contribute	to the cause of death?  Probably 4 DUnknown
	ate has page 2	Completed						24a. Was an autopsy performe 1 ☐ Yes 2X	prior to death?	autopsy findings available o completion of cause of ? es 2□ No
Attending Physician: 7	After this luneral di	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Mann of Death Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 EF  28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	3 DOA Other	er: 4 🗌 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how		Decify)
pital or Attending	24 hours after death • Funeral Diractor: etely filled in by the	i Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town, S	State)	Rural Route Number,
To the Hospital or	within 24 ho To the Function	Medical	29a. Certifier (Check only one)  29b. Signature and line of certifier	sician: To the best of my knowle ner: On the basis of examination and manner stated.	adge, death od n and/or invest	tigation, in my op	pinion, death occur	red at the time, date	e(s) and manner and place, and di	ue to the cause(s)
DE	)		30. Name and address of person who co	ompleted cause of death (Item 2	3a) (Type, Prin	HSY 10 (a sal	CH	sia IAD	2(6)	MO 21804
470	Sta Registr		31. Date filed (Month, Day, Year) FEB 17 20	32. Registrar's Signatur	° <b>1</b> 9	Spark	2 May	, 510103,	MODUN	, MU 21 804

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer Physician 21:40PM George Edward Cottingham, Jr. 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number, Examiner Kegional Wiconico medical Center ninsula If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 □XM 2 □ F 217-42-5662 April 11,1945 58 MD **Director** Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Example at most be notified at 1X Yes 2 No MD Wicomico Be Completed by Funeral Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 East Road U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Painter/Carpenter Property Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F George E. Cottingham, Sr. Sarah Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 901 East Rd., Salisbury, MD 21801 Linda Lewis/friend other Baltimore. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 2005. \* 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Pk 2/14/2004 Salisbury, MD 21. Signature of Funeral Service L 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Road, Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orget and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Cottongham 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No certificate 2 □ **K**o 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of contil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sausbury mo 2/80/ SNYDEN 100 E. CAKROLL m.E. CHRIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2004 07015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ANNA 10:10PM MARIE CRICKENBERGER CUMBERLAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. OCT 3 1,1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 96 224-90-1235 Yrs **Director** STAUNTON, VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Exertinar must be notified at MARYLAND WORCESTER BERLIN 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? items 23a or 21811 5 FISHERMAN'S DRIVE UNITED STATES death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 10 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if item 27 is marked other
any injury or othar traum.... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be PETER M. CRICKENBERGER NANCY REBECCA SHIFFLET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY MARIE CUMBERLAND-DAUGHTER 5 FISHERMAN'S DRIVE; BERLIN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA FEB.10,2004 \* 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DEL. 21. Signature of Funeral Service Liver see 22. Name and Address of Facility HASTINGS FUNERAL HOME, INC. SELBYVILLE, DE 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pukumo, iz Physician day. /Medical De to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Linear Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 2☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DM 5/6/2-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIKIN 9733 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 1 2004 Registrar

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Cumberland,

2-9-04

			1 - For State Registrar	State of Marylan	nd / Department Certificate			6000	07016
			Registrar  1. Decedent's Name (First, Middle, Last		, Oertinicate	or Beatin	2. Date of Deat		3. Time of Death
	Physici		Tommie LE	0	11295		Month	Day Year	0825 M
	/Medic Examir		4a. flacility Name (If not institution, give			own, or Location of Deal	th ,	4c. County of Deeth	• _
			5. Social Security Number 6. Se	yal   Leucal ( x / 7. Age (In yrs.	last birthday) If Under	Year If Under 24 Hrs	8. Date of Birth		place (State or Foreign
	Funeral Director			M 20F 85		Days Hours Min.		Year) Col	intry)
	o o		Usual Residence of Decedent	3 5					
	anylar ehow		10a. State 10b. County		ty, Town or Location				10d. Inside City Limits 14 Yes 2 □ No
	28a-f	ecto	10e, Street and Number	omico	) Alsburg	Code	1	0g. Citizen of What Co	untry?
	h with	Funeral Director	105 Times Sq	MAXE	á	11801		USA	
	eme 2	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Decede	ent of Hispanic Origin? (S by Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
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ary	should be nd Menta nmarked umatic ev	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Address (	Street and Number or R			
	1 and 2 : Health ar tem 27 to		mattie Leader	R = Daughter	2174-27A	-127 AVE.	JACAM	TICA NY	11434
Baltimore	S of T		20a Method of Disposition 1 Z Portal 2 Cremation 3 D	Romaval from State	Place of Disposition (Name cometery, crematory or oth	er blagakeh o	Date	20c. Location - Ity or	Fown, State
ţ	permit. Page Department of Important: If any intery or		* 4 □Donation 5 □ Other (Specify)		Olive BAPTI	Address of Facility	3/04 (	VARTHEN	MA.
Ba	Depa Impo Impo		21. Signature of Funeral Service Licens		The second resu	111	:-1 m	A Service of the State of	inic smith
		$\Box$	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dear	117 し。) 54 th. Do not enter the mode		c or respiratory arr		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	no cause on each inte.	SEPS	15		l)	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec					
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Ö,	cate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	tuence of):				
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Records,	0 4 0	Completed					autops perforr	ned? prior to c	ompletion of cause of
ita	ician: Th certificate ector, pag	0	25. Was case referred to medical			26. Place of De	ath (Check only on	2 No 1 Yes	2 NO
<u>&gt;</u>	Physician: this certific ral director,	To B	examiner? 1 🗆 Yes 2 🗷 No		ER/Outpatient 3□ DOA	Other: 4 Nursing I	Home 5 ☐ Reside	ence 6 Other (Spec	ufy)
o u c	ling P	ion:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28 Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
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Ö	al or / s after il Dire	Certification:	4 Homicide	building, etc. (Special	(y)		City or Town	n, State)	
	To the Hospital or Attending Physician: within 24 hours atter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ledical (	(Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina	owledge, death occurred at ation and/or investigation.	t the time, date and plac in my opinion, death occ	e, and due to the coursed at the time. d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	thin 2, the F mplete	Medi	29b. Signature and title of certifier	and manner stated.		License number		9d. Date signed (Month	
	S 7 & 7		250. Signature and this or partition					•	* *
			30. Name and a dress of person who co	ompleted cause of death (Iter		1 - 1 - 1	7.7	1 covary	4 . 2009
X			1415 S.DI		SALISBURY	MD 21504	· Ilsha	Pebverary. Natesan	
ø	Sta Regist		31. Date filed (Month, Day, Year)  FFR 1 0 201	32. Registrar's Signa	SAUSBURY Apa	uls			

		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 200	+ 07017
Physic /Med		Decedent's Name (First, Middle, L     Carl M. Caud					2. Date of Dea Month +2/3/2/1/A	Day Yeer	
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Funera Directo		215-26-2906	V-V	e (In yrs. last birthday 73 Yrs.	Months Days		8. Date of Birtl in. (Month, Day 6-13-19	9. B (30	irthplece (State or Foreign Country) Va.
Maryland f ahow	ō	Usuel Residence of Decedent  10a. State  10b. County  Md. Worces	ter	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes ② No
s or 28a-	Funeral Director	10e. Street and Number 4806 Carmean Rd			10f. Zip Code	1863		10g. Citizen of What (	Country?
I E, INICAL Y ICATION Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z.	Ď	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? Yayes 2 1 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		(Specify Yes or No- lerto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc. Vhite
d within 72 ho giene. or then "natur the Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5	16a. Dece (Give life.	edent's Usual Occup a kind of work done DO NOT use retire nister	during most of v	working	16b. Kind of Busines Church	s/Industry
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and 2 she ealth and n 27 is my		19a. Informant's Name/Relationship  Carol J. Caudell,	· · ·	4806	Carmean		ow Hill, M		
permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	ify)	Bates Me	ematory or other pla	em. 2-1		20c. Location - City of now Hill,	_
permit. Depart Import	XIIX	21. Signature of Funeral Service Lic	ensee	2	2. Name and Addre Short Fur 13 E. Gre		ome, Inc. Delmar, I	e. 19940	
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ficate be expression of the burial	cai		o. Hy	perdension	27				years.
The Coli day, T.C. DOX 00 (00),  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
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the Hos hin 24 ho the Fun npletely	Medical	(Check only 2 Medical Example)	aminer: On the basis o	f examination and/or it	nvestigation, in my	opinion, death or	ccurred at the time, o	date and place, and du	ue to the cause(s)
10 m	-	29b. Signature and title of certifier  S. A. Raza	Jolali_	ن	Do	060715		29d. Date signed (Mor	2-07,2004
IVA		30. Name and address of person who Reza Jalali 100	East corro	11 st, Sal		031804	(		
S Regis	tate trar	31. Date filed (Month, Pay Year) FEB 1	0 2004 Registy	ar's Signature	9 Spa	els			

215-26-2906

CARL CAUDEIL

OI	314		For State Registrar	State of Maryland / D	Department of H Certificate of L	ealth and Me Death	ental Hygier Reg. N	e2004	07018
34	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Eugene Leonard					Year L8, 2004	3. Time of Death 5:15 P. M
>	Examin Funeral Director		4a. Facility Name (# not institution, give:  1018 Jubilee Court  5. Social Security Number  6. Sec. 18	street and number)  7. Age (In yrs. last birt	4b. City, Town, or Wald hday) If Under 1 Year Months Days	dorf If Under 24 Hrs. 8	3. Date of Birth	Charles County of Death Charles Co  9. Birthp Cour. 939 North	Ounty  lace (State or Foreign
	D	e.	245 – 56 – 3345  Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		une 24, 1		Od. Inside City Limits
	ith the Mai or 28a-f s	Director	MD Charles 10e. Street and Number	Waldo	rf 10f. Zip Code		10g. (	Citizen of What Cour	1 □ Yes 2 X No
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or Items 23e or 28e-f show other than "naturel", or Items 23e or 28e-f show event, the Medical Exam har cust be notified at	by Funeral I	1018 Jubilee Wa  11. Marital Status  1 Never Married 200 Married 3 Widowed 4 Divorced	y 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	20602  13. Was Decedent of Hi If Yes, specify Cubai  1 Yes 2 No		ity Yes or No-	ited Stat  14. Race - Americ Black, White,  Specify: Whi	ean Indian, etc.
21215-0036	I within 72 hour iene. r than "naturel the Medical E.	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a. completed) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired, ivil Service	<sup>luring most of working</sup> Security		Kind of Business/Ind	dustry
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	nd 2 s lith ar 27 is r treu		19a. Informant's Name/Relationship (Ty Valerie Grimes-d	aughter 28	Mailing Address (Street a	Street, E	Bryansroa	d, MD 206	16
Baltimore,	m O		20a. Method of Disposition  1  Burial 2  Cremation 3  F  4  Donation 5 Other (Specify)	iemoval from State	Disposition (Name of y, crematory or other place Crematory	· .	-2004 Wa	Location - City or To	wn, State
Balt	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Licens  Tock The County  23a. Part1. Enter the disease, or compl	CONTINUE	22. Name and Addres Huntt Fune P.O. Box 1	ral Home	∘f MD 20	604	
60,	Physician and /Medical Examiner physician and physician and physician and the physician it is the physician and ph	al Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	ion and to	g, such as cardiac or	1 MM	y	Approximate Interval Between Onset and Death
.O. Box 68760,	death certiff e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ory Day Year
s, P	es thi	ρ	Part II. Other significant conditions con	ntributing to death but not resulting in	n the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
Vital Record		Completed					24a. Was an autopsy performed?	prior to con death?	psy findings available mpletion of cause of 2 No
Vita	Physician: The this certificete ral director, pag	o Be	25. Was case referred to medical examiner?  1 💆 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Othe	26. Place of Death (	Check only one)  e 5 TResidence	6)Other (Specific	»At scene
sion of	tending Phy leath. tor: After thi the funeral o	atlon: T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury 28b. 7	Time of 28c. Injury	at 28	d. Describe how in	jury occurred	
Division	P S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, fa building, etc. (Specify)	rm, street, factory, office	u	City or Town, Sta DALDORF	and Number or Rura are) 1018 Jub CHARLES	CO. MD
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	Medical		sician: To the best of my knowledge ner: On the basis of examination and and manner stated.					
	To th within To th comp	Me	29b. Signature and title of certifier.	M	29c. License OCME	number		Date signed (Month, pruary 19,	
Y	85		30. Name and address of person who co	omple ed cause of death (Item 23a)	(Type, Print) 111 Per	nn Street,	Baltimor	ce, Maryla	ınd 21201
	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 3	32. Regulara's Signature	. Sparte			· · · · · · · · · · · · · · · · · · ·	

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			State of Sta	f Maryland	Depa Cer	artment of H	lealth ar Death	nd Me	ntal Hy	giene Reg. No.	2004	0701	
ı	Physici		Decedent's Name (First, Middle, Last)	Davenport					Date of De Month Pebrua	Day	1, 2004	3. Time of Death 11:10 P	
À	/Medic Examin		4a. Fecility Name (If not institution, give street and nu Carriage Hill Nursing	mber)		4b. City, Town, or Bethe	_			4c. (	County of Death		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 № F	7. Age (In yrs. last 88	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8 Min. J	Date of Bir (Month, Da uly 1	th iv. Year) 5, 19	9. Birthp Coul Nort	place (State or Foreig ntry) h Carolina	
	hours after death with the Maryland turel', or items 23e or 28e-1 ehow al Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery  10e. Street and Number  4604 Drummond Avenue	10c. City, To		y Chase 10f. Zip Code 20815				-	en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or Itama 23a or 28a-1 show avent, the Madical Examinar must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dec Armed F. 1 Yes, Giryear or Divorced	2 X No ve pates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☒️ No	Specify:	n? (Specif Puerto Ric	Rican, etc.) Black, W		4. Race - Americ Black, White, Specify: Whi	ite	
Maryland 21215-0036	12 should be filed within 72 ho h and Mental Hygiene. 7 Is marked other then "natu traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College ( 4  17. Father's Name (First, Middle, Last)		(Give	dent's Usual Occup kind of work done DO NOT use retired Teacher	during most o		First, Middle	Wake	County Systems	•	
yland	nould be fi I Mental H narked ot natic ever	To Be	James Owen Pernell		IOh Maili	ng Address (Street	Dai	sy Co	ox Pe	rne1	1	n Codel	
	1 and Healt am 2 ther		19a. Informant's Name/Relationship (Type, Print)  Shannon Kaplan/ Daughte  20a. Method of Disposition	r 1	221	Canterber	cry Rd		leigh	, NC	27608		
Baltimore,	it. Pages atment of atmit: If it njury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Fore	st H	ill Cemet	ery 2				ville, N		
Ra Ra	permit. Departr Imports eny inj		Mulino (. Ke	M0129	51	2. Name and Addre	nsin A	ve.,	NW, W	lashi			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Dysphagia  Due to [or as a consequence of):										
8760,	Examiner sician and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Actuals  Due to	ite Hemori (or as a consequen rebral Vas (or as a consequen pertension	rhagi ce of): scula ce of):							3 days Years	
.O. Box 687	ath certificate ttending phys or use as the	Physician/Medical	in the past 12 months?	itcome of pregnancy birth 2 Tetal de nant at time of death	ath 3	Ectopic pregnancy Other (specify)	,			2	3d. Date of delive	rery Day Year	
٩.	uires that the des signed by the a d be detached f	þ	Part II. Other significant conditions contributing to a Seizure disorder	leath but not resulting	ng in the u	nderlying cause giv	en in Part I.					the cause of death?	
Recor	The law require ate has been signage 2 should b	Completed	Alzheimer's Disease						24a. Was auto perfe 1 \( \text{Yes} \)		24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of	
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be			/Outpatier	Wor	er: 4 💢 Nurs	sing Home	Check only 5 ☐ Res d. Describe	idence 6	i □Other (Specii r occurred		
Divis	tel or Attendi s after death. sl Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home ling, etc. (Specify)	, farm, st	reet, factory, office		28		(Street and wn, State)		al Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	Α			vestigation, in my o	pinion, death			date and	place, and due t	to the cause(s)	
ı	To the within 2 To the complet	Σ	29b. Signature and lifte of certifier	h	>	D355					signed (Month, ruary 12		
-	•		30. Name and address of person who completed cau Susan J. Miller, M.D.			Print) Hill Terr	ace, B	ethe	sda, M	ID 20	0816		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. I	Pegistrar's Signature	13	Spork	1						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

			1- For Amend Item #	23a per phy	6829 <sup>1</sup> 572 Ce	artment 23/04 rtificate	tas of C	eaith and iv <i>Peath</i>	ientai Hygie Rec	ene 200	4 07021
	Dhysisi		1. Decedent's Name (First, Middle, La						2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		Henry Marti		rowski	,			February		
	Examir	er	4a. Facility Name (If not institution, give			4b. City, T	own, or l	ocation of Death		4c. County of De	eath
-	Funeral		14120 Hucklebe 5. Social Security Number 6. S		rs. last birthday)			er Sprin If Under 24 Hrs.		Montgo	mery lirthplace (State or Foreign
	Director		125-05-4502	⊠M 2□F 97	Yrs.		Days	Hours Min.	8. Date of Birth (Month, Day, Y	1906 Ne	W York
	D .		Usual Residence of Decedent  10a. State 10b. County	10-	C: T						
	Aanyla Fahor	ō			City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28a-	Director	Maryland Montgo  10e. Street and Number	mery	Silve	r Spri			100	Citizen of What (	
	h with		14120 Huckleberr	v Lane				906	1.03	USA	Southly !
	ams ams	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decede		panic Origin? (Spe Mexican, Puerto	cify Yes or No-	14. Race - An	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itams 23s or 28s-f show any injuryer other traumatic event, the Michiel Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 192		1 ☐ Yes 2		Specify:	nican, etc.)	Black, Wh	
5	natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual kind of work	done du	on ring most of worki	20	b. Kind of Busines	
72	within ene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use artogra	_	-		J.S. Depa Agricultu	rtment of
0	Hygie other	a	17. Father's Name (First, Middle, Last)	1	02	artogra	-		(First, Middle, Ma		.16
ılar	should be ind Mental I marked o umatic eve	To B	Stanislaus Domb	rowski				Euphei	nia Flis		
Maryland	2 should be and Mental Is marked craumatic ev		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (	Street an			city or Town, State,	Zip Code)
	s 1 and 2 of Health ar Item 27 is other trau		Cathy H. Dombrow 20a. Method of Disposition		r 1412 D. Place of Dispo	20 Hucl	kleb				MD 20906
Baltimore,	Pages nent of I		1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	cernetery, cremate of 1	natory or oth	er place)	Febru	ary 19	c. Location - City o	
altir	permit. Page Department Important: If any injury once.		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Cemet	ery 2. Name and	Address	of Facility		Silver Sp	ring, MD
<u>~</u>	Departing Department Important in Sany is sany	d d	MANUMAN	eparker	. F1	rancis OO Uni	J. vers	Collins   itv Blvd	Funeral H	lome Inc. ver Spri	ne. MD 2090
()E	<i>\$</i>		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	ligations that caused the done cause on each line.	ath. Do not ent	er the mode	of dying,	such as cardiac o	respiratory arrest	· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer'	Dement	12					Onset and Death Years
	Examiner			Due to (or as a cons	equence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):						
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.							
8760,	ficate be executed physician and s the burial-transit	aE		Due to (or as a cons	equence of):						
9		edicai		d							
Вох	eath certifi attending for use as	M/M	23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo		T-1				23d. Date of de	livery
О.	e dea the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time o		Ectopic preg Other (spec				Month	Day Year
<u>.</u>	res that the de signed by the a l be detached t	Phy	Part II. Other significant conditions co	ntributing to death but not r	esulting in the up	nderlying cau	se awan	in Part I	23a Did tahan	CO Lisa contributo t	o the cause of death?
Vital Records,	The law requires that the death cert the has been signed by the attending age 2 should be detached for use ?	Ω				raony ing out	30 311011				robably 4 DUnknown
O O	aw require ts been si 2 should t	Completed							24a. Was an	24b. Were a	utopsy findings available
		E O							autopsy performed 1 ☐ Yes 2 🛣	prior to death?	completion of cause of
/Ita	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				2	6. Place of Death			. 22110
-	sic b	ပ	1 ☐ Yes 2 ☒ No 27. Manner of Death		ER/Outpatient					6 ☐Other (Spe	ocify)
o	ding th. : After fune	ţ	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	2 □ No	3d. Describe how in	njury occurred	
Division	Atter er dea ector by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, o			3f. Location (Street	and Number or Ri	ural Route Number,
5	itatoy ars afte ral Dii								City or Town, Si		
	To the Hospital or Attending Plantin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one)  1X Certifying Phy 2 Medical Exam	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at t estigation, in	he time, my opini	date and place, ar on, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	With Com	Σ	29b. Signature and title of certifier	5 1	R	29c. L	icense n	umber	29d.	Date signed (Mont	h, Day, Year)
	8+1	-	P Mailin	- Ohazel	N)		0884	4	Fel	oruary 16	5, 2004
			30. Name and address of person who commartin C. Shargel								
					rraoni	ATTANIIA	. Ka	ncinoto-	MID OUG	1 5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23apt 11 25 / 28a-f. per me 842 4-7-05 with the Amend items 23apt 12 25 / 25a /

1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 13, 2004 11:15PM Physician C. DYSON Sr. CLIFTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Hebrew Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 11 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Year) **Funeral** M M 2□F ,1935 68 Director 218-30**-**3003 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 shot any highry or other traumatic event, the Mudical Extrainist must be notified at once. 1.3 1 XYes 2 No Funeral Director Potomac Montgomery Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20854 7863 Scotland Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community Auto Co. Service Worker 6th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen McRoy Charles Dyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7863 Scotland Dr, Potpmac, Md #20854 Clifton C. Dyson Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Md 2/20/04 4 ☐Donation 5 ☐ Other (Specify) Gate Of Heaven 21. Sign ture of Funeral Service LL nsee 22. Name and Address of Facility Snowden Funeral Home F 246 N. Washington St. P.A. 20850 Rockville, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiorespirator Priysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed LAPPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Box 68760 Physician/Medical CERTIFICAT IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 ☐ Unknown decubitus 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an para page 2 autopsy performed? 2 No 1 Yes 2 No ease 1 ☐ Yes certificate Diabetes mellitus Division of Vital I To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To this After this funeral of 28b. Time of Injury 28c. Injury atunknown 28d. Describe how injury occurred Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 5 Pending unknown 1 ☐ Yes 2 ☐ No unknown unknown M within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide unknown unknown 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20055362 1 RINA SECYA H. D. Kasser permanente. 30. Name and address of person who completes cause of death (Item 23a) (Type, Print) USEN ST 2/0/ DORV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State eperane. Darks Registrar

State of Maryland / Department of Health and Mental Hygiene 20041 - For State Registrar 07023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 27, **Physician** February 2004 Eugene Mathias Dinterman 3:00 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5739 Bells Lane Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Days Hours Min. Nov. 15, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⋈**M 2□F 63 Country) Maryland 212-38-9609 Yrs. Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location r items 23s or 28s-f show 10d. Inside City Limits Maryland Directo Frederick 1 ☐ Yes 2 ☐ No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5739 Bells Lane 21704 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates: 1 ☐ Never Married 2 ☐ Married r than "natural", or 1 ☐ Yes 21 No ģ Specify: 3 ☐ Widowed 4 ★ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Ite Mustic one. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ward Mathias Dinterman Margaret V. Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Dinterman/Son 8945 Alabama Street, Riverside, California 92503 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Smithsburg Crematory March 1, 2004 Smithsburg, Maryland 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service Licensee Keeney and Bastord Funeral Home 100021 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown signed by t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Yeer) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending To the Hospitel or Attendii within 24 hours after death, To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of and manner of stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35164 and address of person who ampleted cause of death (Item 23a) (Type, Print) 15 West 7th St. Frederick, MD 21701 marein 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2001 Registrar 4

DHMH 17 Rev 1/2001

**ORIGINAL** 

	State     Registrar  1. Decedent's Name (First, Middle, La	st)	Certificate of Death	Reg 2. Date of Death	1. No. 2004	3. Time of Death
Obvesioion	AUDREY L. DANIELS	.,		Month 62 /	Day Year	0205 M
weulcai	4a. Fecility Name (If not institution, giv	re street and number)	4b. City, Town, or Location of Deat		4c. County of Death	1 -
iiiei	Pen/INSULA REGIONA		PENTU SALISBUM	1	HICON	
	5. Social Security Number 6. S 029-16-5941	Sex 7. Age (In yrs. 1 ☐ M 2√☐ F 81	last birthday) If Under 1 Year If Under 24 Ars  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear)   Cou	pplace <i>(State or Foreig</i> i Intry) ACHUTES
	Usual Residence of Decedent					
<u> </u>	10a. State 10b. County		y, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Director	MD WICOMICO	) PITT	TSVILLE 10f. Zip Code	100	2. Citizen of What Cou	
	10e. Street and Number	30 A D		109		artiy.
era	4951 POWELLVILLE I	12. Was Decedent Ever in U	.S.   13. Was Decedent of Hispanic Origin? (5   If Yes, specify Cuban, Mexican, Puer	specify Yes or No-	USA 14. Race - Amer	
by Funerai	1 ☐ Never Married 2 ☐ Married 3 🛱 Wildowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 🕅 No Specify:	to Rican, etc.)	Black, White	, etc. ITE
	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16	b. Kind of Business/li	ndustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	POSTAL WORKER	τ	J.S. POST	OFFICE
Be C	17. Father's Name (First, Middle, Last	)		me (First, Middle, Ma		
To B	CHARLES WELLINGTON	N GARLAND	PHOEBE	MOUNTAIN		
	19a. Informant's Name/Relationship (	**	19b. Mailing Address (Street and Number or R.			
	RICHARD DANIELS -		5741 SEXTY FOOT ROAD,			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or 1	
	*4 □ Donation 5 □ Other (Special		MATORY OF DELMARVA 02-			
	21. Signature of Funeral Service Lice	nsee	22. Name and Address of Facility BO 705 EAST MAIN STRE			
	23a Part 1. Enter the disease or com	polications that caused the deat	h. Do not enter the mode of dying, such as cardia			Approximate
	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				Onset and Death
	disease or condition resulting in death)	Due to (or as a conseq	otic Colon Cance uence of):	<i>*************************************</i>	(	X/2 year
Examiner	Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or).			
ca	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):			
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Il death 3 Ectopic pregnancy		23d. Date of delin Month	very Day Year
		contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
d by				1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
2				24a. Was an	24b. Were aut	opsy findings available
Sie.				autopsy performe 1 Yes 2	death?	
ompie		T	26. Place of De	ath (Check only one)		
le Completed	25. Was case referred to medical		Cther.	Home 5 Residence	ce 6 □Other (Spec	ify)
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	Produtpatient 3 DOA 4 Nursing i		injury occurred	
To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Marural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 Yes 2 No	28d. Describe how		
To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Injury at Work?  M 1 Yes 2 No  ome, farm, street, factory, office		et and Number or Rui	ral Route Number,
Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Pl	28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At he building, etc. (Special hysicien: To the best of my known of the second of	28b. Injury at Work?  M 1 Yes 2 No  ome, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State) se(s) and manner as	stated.
To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined.  29a. Certifier Check only 2 Medical Examiner.	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specific hysicien: To the best of my knominer: On the basis of examina	28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  ome, farm, street, factory, office  owledge, death occurred at the time, date and place	28f. Location (Stree City or Town, S e, and due to the cau- urred at the time, date	et and Number or Rui State) se(s) and manner as	stated. to the cause(s)
Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending investigated 3 Suicide 6 Could not be determined.  29a. Certifier (Check only one)  1 Certifying Place (Check only one)	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specific hysicien: To the best of my knominer: On the basis of examina	28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No ome, farm, street, factory, office by owledge, death occurred at the time, date and place attion and/or investigation, in my opinion, death occurred.	28f. Location (Stree City or Town, S e, and due to the cau- urred at the time, date	et and Number or Rui State) se(s) and manner as a and place, and due	stated. to the cause(s)

			1 - For State Registrar	State	of Marylar		artment rtificate			d Mental	Hygier	/	004	0702
			Decedent's Name (First, Middle, L.	ast)						2. Date	of Death	Day	Year	3. Time of Death
	Physici /Medio		Amos A. Dashiel	L							UDRY	7, 2	004	2335 ™
200	Examin		4a. Facility Name (If not institution, gi			01.	4b. City, To	own, or Loc	cation of De	eath		4c. County		
			100100	70.7.0	nedical		If Under 1	9140	Under 24 F	les o D	4 Diah	Wic	ins	
	Funeral		5. Social Security Number 222–03–8206	Sex 11 <b>2</b> 0 M 2 □ F	7. Age (In yrs. 84	Yrs.				in. (Mont	h, Day, Yea	ar) Q1 Q	Coun	lace (State or Foreign try) MD
	Director		Usual Residence of Decedent		0.1		1			Dury	13,1	717		<u> </u>
	yland		10a. State 10b. County			ty, Town or Lo							11	Od. Inside City Limits
	la-f	cto	MD Wicomio	CO	Sa	lisbur	_							1 ∑Yes 2 ☐ No
	ith th	Dire	10e. Street and Number	. 47	27.1		10f. Zip C				10g. (	Citizen of W		try?
	a 23a	rai	Riverside Dr., A		ALADAMA Cedent Ever in U			801	nic Origin?	(Specify Yes	or No.	U.	S. - Americ	an Indian
_	ter de	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed F 1 ☐ <b>X</b> Yes	orces? Ai	r	If Yes, specifi	y Cuban, N	Mexican, Pu	erto Rican, etc	:.)		k, White,	
9	urs af	þ	3 Widowed 4 Divorced	If Yes, G Year or	Dates: Forc	e	1 ☐ Yes 2[	XNo S	pecify:			Specify:	Blac	ck
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itema 23a or 28a-f ahow dother than "natural", or itema 23a or 28a-f ahow avent, the Medical Examinar match provided at	Completed	15. Decedent's to (Specify only highest g		)		dent's Usual			working	16b.	Kind of Bu	siness/Ind	lustry
21	within lene.	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use					,	c = 1	
22	filed w Hygier other th		12 17. Father's Name (First, Middle, Las	t)	_		Cust	odiar		lame (First, M				cation
auc	should be filed and Mental Hygi marked other imatic avant, I	) Be	William Addison I		L					a Brown	, , , , , , , , ,		-,	
Maryland 21	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic ava	2	19a. Informant's Name/Relationship			19b. Maili	ng Address (			Rural Route N	umber, City	y or Town, S	State, Zip	Code)
	nd 2 lith a 27 is r tra		Constance Sturgis	s/sister	<u>-</u>	1054	6 Harr	ison	Rd.,	Berlin	, MD :	21811		
č,		i	20a. Method of Disposition		/	Place of Dispo cemetery, crea	sition (Name	of		Date		Location - (	City or To	wn, State
Ē			1 Surial 2 ☐ Cremation 3 1  Other (Spec		Md	Vetera	ns Cem	etery	/ 2/1	7/2004	Hu	rlock	MD	
Baltimore,	permit. Page Department of Important: If any injury or pnce.		21. Signature of Funeral Service Lice	0		L	Name and eWis N	Address of Wat	Facility	uneral	Home			
	70 = 4 d					1	<u>618 We</u>	st Ro	pad, S	Salisbu	ry, M	D 2180	01	Approximate
			23a. Part1. Enter the disease, or conshock, or heart failure. List onf	one cause on	each line.	tn. Do not en	er the mode	or dying, si	uch as card	liac or respirati	ory arrest,			Interval Between Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HT		MYOCF	PDIA	L 1N	FAR	CTION			-	45 min
	Examiner			Due to	(or as a consec	1101 / 100	15 Out 5	21012	105					, rigore
30		e e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq		TERY I	1261	125					
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· C	ONGES	TIVE	HEAR	TF	AILV	RE				48 hrc
ĵ	an an		resulting in death) Last	Due to	(or as a conseq	quence of):								
8/60	certificate be executed utility by sician and use as the burial-transit	Icai	•	d										
9	0 0	Physician/Med	IF FEMALE:	230 If yes o	utcome of pregna	ancy						004 0-44	at dati a	
Rox	atter for u	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3	Ectopic preg					23d. Date Mon	of delive th	ry Day Year
o.	g o g	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki		102(1)	1 O (1 let (3pec							
J.	The law requires that the tite has been signed by thoage 2 should be detache	by Ph	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cau	ise given in	Part I.	23e.	Did tobacco	o use contri	bute to th	e cause of death?
rd S	w requires been sign should be		VENTRICUL	AR AF	2RYTHN	)1A				-	1 🗌 Yes	2 □ No	3 🗀 Proba	ably 4 Unknown
ecords,	s bee	piete	HYPOKALE	MIA							Was an autopsy	24b. W	ere autop	sy findings available
r	The lay ate has page 2	Completed		BTRU	CTIVE	PULMO	NARY	Dis	SEAT	- 10 Y	performed?	de de	eath?	
Vital	ysician: The is certificate hadirector, page	ВеС	25. Was case referred to medical examiner?				1 1 1 1	26	. Place of D	Death (Check of	n <i>ly one)</i>			
> 0	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 🗌 Nursin	Home 5				)
Ĕ	ding P h. After I tunera	on:	27. Mann  f Death 1		nth, Day Year)	28b. Time o Injury	M 280	Work?	2 □ No	28d. Desc	ribe how in	jury occurre	ed	
210	uttendi death. ctor: A y the tu	icat	2 Accident investigati 3 Suicide 6 Could not	be 280 Plac	e of Injury - At h	ome farm str			2 🗆 140	28f Locat	ion (Street	and Numbe	r or Rural	Route Number,
Division	I or At after d Direct	Certification:	4 Homicide determine	build	ding, etc. (Special	(y)	det, factory, t	Silico			r Town, Sta			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely illed in by the funeral director.		29a. Certifier 1 Certifying F											
	n 24 h	Medicai	(Check only 2 Medical Exa	miner: On the and ma	basis of examina nner stated.	ation and/or in	vestigation, ir	n my opinio	on, death o	curred at the t	ime, date a	ind place, a	nd due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	3				License nu			29d. D	Date signed	/	/
			17010					425	22		2	101/	200	4
A			30. Name and address of person who	1	se of death (Iter	п 23a) (Туре,	Print)	- /	la	Drive	Λ.	0 = 0		1100 7 : P-1
	Sta	to	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	_ane	m&	-Cere	DYIVE	120	Walm	ny	my 21801
	Sta Registr		FEB 1 2 20		eneva	B	Spor	K						

			1 - For State Registrar	State o	f Marylan	_	artment of F		d Mental Hy	/giene Reg. No. 2	004	07026
			Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia		PAULINA	I	4 •	De	FLORES		2	5	04	5:45-PM
>	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	or Location of C	eath	4c. Count	y of Death	
			ATLANTIC GENERAL	HOSPITA	L_		BERL			1	ORCES	
	Funeral		5. Social Security Number 6	5. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		Hrs. 8. Date of B	irth 2, 1924	9. Birthp	lace (State or Foreign try) ALVADOR
	Director		212-27-9014	1 L M 2 D F	79	Yrs.			JUNE 2	2, 1924	ELS	ALVADOR
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	aryla shov	5	DELAWARE SUSSI	v		ELBYVI						1 ☐ Yes 2 📉 No
	the N	Director	10e. Street and Number			, LLD I V I	10f. Zip Code			10g. Citizen of	What Coun	try?
	with a or	급	RT. 7 BOX 88C				19975			EL SA	LVADO	R
	leath ns 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or N ruerto Rican, etc.)	0- 14. Ra	ce - Americ	
(0	r iter	Fun	1 ☐ Never Married 2 ☐ Marrie	d 1 ☐ Yes	2 🔯 No		r Yes, specify Cuba 1 A Yes 2 □ No				ick, White,	
21215-0036	raf, o	þ	3 X Widowed 4 ☐ Divorced	If Yes, Gi Year or E	ve lates:		Tes ZEINO	эрөспу: С	SALVADORAN	Speci	y: WH	ITE
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b, Kind of E	Business/Ind	lustry
2	rithin ne. han "	ld II	Elementary/Secondary (0-12)	College (	1-4or 5+)	!	IOMEMAKER			OWN	HOME	
2	be filed within 72 hours after death with the Maryland nia! Hyglene. or other than "natural", or items 23a or 28e-f show event, the Medical Examinating to attached at		17. Father's Name (First, Middle, Li	iet)			IOTILITAREIX		Name (First, Middle			
Maryland	ed a b	) Be	ANSELMO		ERNANDA 2	2			LVADORA	VIRGIN		MATA
Z.	d 2 should th and Mer ?7 is marke traumetic	To.	19a. Informant's Name/Relationshi			-	ng Address (Street	and Number o	r Rural Route Numb	ber, City or Town	, State, Zip	Code)
	22.2		LUCIA ZERVAKOS/	OAUGHTER		RT. 7	BOX 88C	, SELBY	YVILLE, D	ELAWARE	19975	
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation		20b. F	Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	- City or To	wn, State
Ē	Page nent ant: If		`4 □ Donation 5 □ Other (Spe		CRI	EMATORY	OF DELM	ARVA :	2/7/04	DELMAR,	DELA	WARE
att	permit. Departr Importe any inju		21. Signature of Funeral Service Li	censee//	_		. Name and Addre	-				10075
<u> </u>	89 = 29		Voterun	The					HOME, SE		DE.	
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	ny one cause on	caused the deat each line.	h. Do not ent	er the mode of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	16	18600	VESC	clar	200	cident			2 days
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):						
~	LXammer	_	Sequentially list conditions,	b. — Due to	(or as a conseq	uagas of):						
77	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	uence or):					- 1	
3004	and all-trar	xan	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						
5/2/	death certificate be executed e attending physician and id for use as the burial-transit	cal E		4								
200	ficate p phy:			0.						- Ja		
	leath certifical attending phy I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		1r			23d. Da	ite of delive	ry
Dog S	death e atte d for	cla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Preg	oirth 2 ☐ Feta nant at time of d		]Ectopic pregnancy ] Other <i>(specify)</i>	<u> </u>		Me	onth	Day Year
5. P.O.		Physician/Med	9 Unknown	9□ Unkr	own							
nes ls, P.	The law requires that the Ite has been signed by th page 2 should be detache	ру Р	Part II. Other significant condition	s contributing to a	eath but not res	ulting in the u	nderlying cause giv	en in Part I.		,		e cause of death?
	en si			_			<del> </del>		_ 1	Yes 2 46	3 Proba	ably 4 🗀 Unknown
6/19 6/4 ecor	elawr hasbe le 2sh	ompleted							24a. Was	s an 24b.	Were autop	osy findings available inpletion of cause of
60E		Сош							perf	ormed? 2 D No	death? 1 🗌 Yes	2 <del>3 N</del> 0
7 - 7.	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		/		- la		Death (Check only	one)		
110 of V	Physic this c	မှ	1 ☐ Yes 2 ☑ No	100		ER/Outpatien		4   Nursir	ng Home 5 ☐ Res			)
		lon:	27. Mann f Death 1 ✓ atural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2∐No	28d. Describe	how injury occur	rea	
Paul 212 Ision		cat	2 ☐ Accident investigated investigated and accident investigated and accident investigated inve	t be Oss Diss	of Injuny - At he	ome form etc	M 1 []	10S 2 110	28f Location	Street and Numb	ner or Rura	I Route Number
Paux 212 Division	2 a a c	Certification;	4 Homicide determin	ed build	ing, etc. (Specif	y)	eet, factory, office			wn, State)	707 07 7 tg/ 27	riodio ridingon
_	Hospital or 24 hours afte Funeral Dir tely filled in								lace, and due to the			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	(Check only 2 Medical Ex	ceminer: On the b and man	asis of examina ner stated.	tion and/or inv	estigation, in my o	pinion, death o	occurred at the time,	date and place,	and due to	the cause(s)
	You withi Tou	Σ	29b. Signature and title of certifier	10 11		,	29c. Licens	e number		29d. Date signe	d (Month, L	Day, Year)
	<b>&gt;</b>		10-2		- ph	151612	- 444	1283		2/5/0	14	
1-1	2		30. Name and address of person w	no completed cau	se of death (Item	23a) (Type,	6	× -	. 0.	0.	^	
5 V			31. Date filed (Month, Day, Year)	20 5	9 7 5 5 Registrar's Signa	ture '	Thudy	Dun	Blu	Krs, a	20	
	Sta Registr		FEB 1 1		Genera	1	Sport	2				
			<b>→</b> -				- /					

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Ctota of Mondand / Descriptions of Health and Ma		0.0	1
State of Maryland / Department of Health and Me	ntai Hygiene	UH	į,
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		•	1 - For State Registrar	State	of Maryla				lealth a Death	nd Me	ental Hygi	ene2 g. No.	004	070	027
			1. Decedent's Name (First, Middle, I	Last)							2. Date of Death	)		3. Time o	of Death
	hysici: Medic/		Ernest Edward E	ast <b>e</b> p,	Jr.					]:	Month February	Day	, 2004	9:01	Р м
	Examin		4a. Facility Name (If not institution, g	rive street and n	umber)		4b. City	, Town, or	Location of	Death		4c. C	ounty of Death	1	
			916 Venice Dr						Sprin			Mo	ntgome		
	ineral			Sex 1X M 2 ☐ F		s. last birthday,	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,			iplace (State intry)	
	rector		577-24-1993 Usual Residence of Decedent			80 Yrs.					Sept 20.	. 19	23 Was	shingto	on, Do
yland	MOL		10a. State 10b. County		10c. C	City, Town or L	ocation							10d. Inside C	City Limits
Mar	pelling Diffing	ctor	Maryland Montg	omery	S	ilver S	brin	<u>o</u>						<b>X</b> □ Yes	2 No
ë :	or 28	Dire	10e. Street and Number				_	p Code			10	g. Citize	n of What Cou	intry?	
death with the Maryland	rai', or items 23a or 28a-f ehow Examiner raust be notified at	Funeral Director	916 Venice Dr						0906			USA			
er de	items Der n	une	11. Marital Status	Amed I		U.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)	14	<ul> <li>Race - Amer</li> <li>Black, White</li> </ul>		
rs aft	l', or		1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	If Yes, C	: 2 ⊡ No Give W Dates:	WII	1 🗆 Yes	2 XN0	Specify:			S	pecify:	T.71	
2 Pg .	atura cal E	Completed by	15. Decedent's	Education		16a. Dece					- 1	6b. Kind	l of Business/li	White	
Maryland 21213-0036 d 2 should be filed within 72 hours af	Mad a	pie	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of w DO NOT i	ork done d ise retired	during most ( )	of working	9			•	
d wit	# # H	PO.	12		(, , , , , , , , , , , , , , , , , , ,	S	urvey	or				U. S	S. Gove	rnment	_
ਤ ਛੋਵੇ ਜੋਵੇਂ	Vent	Be (	17. Father's Name (First, Middle, La	st)					18. Mother	's Name	(First, Middle, M				
Tal ylailla 2 12 13-0030 2 should be filed within 72 hours after deal and Mental Hygiene.	atic	ပို	Ernest E. Easter								la Goche				
2 sh	Tauer Fauer		19a. Informant's Name/Relationship	(Type, Print)		10.000					Route Number,				
Tand Health	em 27 ther t		John Eastep/Son 20a. Method of Disposition		20h	335 Place of Dispe	E. Wa	shin	gton.	St, f	18, N.	Att	lhoro,	MA	
Definit. Pages 1 at Department of Hea	= 5		1 X Burial 2 ☐ Cremation 3		n State	cometery, cra	matory of	otrier piac	9)		655				
it. P.	Important: If item 27 is marked other than "naturenty injury or other traumatic event, the Musical once.	-	*4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Me	adowrie	dge M	em Pa	ark F	eb 1	6, 2004	_E1	kridge	. MO	
Depa	eny i		Llurane (A	A A	01.11	-	2. Name a	na Adares	s or Facility	Hine	es-Rinal Ave, Si	di E	Tuneral	Home	-02-2-30-0-1
/Me Exar	physician and edical miner transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entire funderlying Cause (Disease or injury that initiated events resulting in death) Last	b	o (or as a conse	equence of):	MAON	W3 CL	ind C	7 is ev	M			Onset and	Death
the death certif	by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregr birth 2 ∐ Fe gnant at time of nown	tal death 3	⊒Ectopic p ⊒ Other <i>(s</i> į					230	d. Date of deliv Month	-	Year
quires tha	sign d be	þ	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying (	cause give	n in Part I.				contribute to t		
	2 2	Completed								_	24a. Was an autopsy performe	1	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings impletion of c	available ause of
OI VILAI Physician: T	certificate rector, pag	Be	25. Was case referred to medical examiner?					-	26. Place o	of Death (	Check only one				
Physi	this c aldire	P	1 Yes 2 □ No			☐ ER/Outpatier			4 L Nurs		5 Residen			fy)	
guil	or: After I	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigate  3 Suicide 6 Could not	on	of Injury nth, Day Year)	28b. Time o Injury	M	28c. Injury Work 1 🔲 \	at ? ∕es 2 □ No		d. Describe how	injury o	ccurred		
5 5 5	To the Funeral Director: After this certificate hi completely filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Plac	ce of Injury - At I ding, etc. (Spec	home, farm, str lify)	eet, factor	y, office		28	f. Location (Stre City or Town,	et and N State)	lumber or Rur	al Route Num	iber,
To the Hospital	ne Fune detely fil	edical	29a. Certifier 1 Certifying I	aminer: On the	ne best of my kn basis of examin nner stated.	nowledge, deat nation and/or in	n occurred vestigation	at the tim	e, date and inion, death	place, an occurred	d due to the cau at the time, date	se(s) an e and pla	d manner as s ace, and due to	tated. the cause(s	5)
To the within	To the	ž	29b. Signature and title of certifier		1.	. \	29	c. License			1		igned (Month,		
10				- 1	~0. (D)	ME)		DIS	236		F	5 kr La	Fy 18, 20	404	
10			30. Name and address of person wh							4568					
			Carl Margolis,				e Pik	e, R	ockvil	Lle,	MD 2085	2			
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 9 2	004 32.	Registrar's Sign	fature &	So	31/2	/						

ADH BRIA 04-1

AN 10	A. ERF	AIN	Please Ty	pe or Print in Black In	delible ink. Ensure Al	Copies Ai	re Legible.
10	83		For State Registrar	state of Maryland / Depa Ce	artment of Health and M rtificate of Death	ental Hygie	
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medio			rfan		FEBRUARY	9, 2004 0040 A M
>	Examin		4e. Facility Name (If not institution, give stre MONTGOMERY GENERAL		4b. City, Town, or Location of Death  OLNEY		4c. County of Deeth MONTGOMERY
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign
L	Director		216-94-2806 TWAM Usual Residence of Decedent	2□ F 37 Yrs.	Worlding Day's Fronts I was	March 8	1966 Maryland
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Ba-f st	Director	Maryland Montgome	ry Bethes	T	140	1 X Yes 2 No
	with th		10e. Street and Number 8015 Rising Ridge	Road	10f. Zip Code 20817	109	. Citizen of What Country?  U.S.A.
	ma 23	Funeral			Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
21215-0036	72 hours after deeth with the Maryland natural', or itema 23a or 28a-f show otcal Examiries frust be natified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 20XNo	1 Yes 2 No Specify:	Hican, etc.)	Black, White etc.  Specify: White
5-0	natur	ieted	15. Decedent's Educat (Specify only highest grade of	ion 16a. Dece (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16	b. Kind of Business/Industry
121	d within 72 ho piene. r then "netui the Medical	Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	les Associate		Retail
b	a filed at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)			(First, Middle, Ma.	
ylaı	thould be ad Mental marked o	To	Dr. Bahram Erf			h Gunsall	
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic engines.		19a. Informant's Name/Relationship (Type, Dr. Bahram Erfan -		ng Address (Street and Number or Rura Rising Ridge Road		
	Heali Heali tem 2		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or Town, State
E O	Page int: If it		1 ☐ Burial 2 ⚠ Cremation 3 ☐ Rem  1 ☐ Donation 5 ☐ Other (Specify)	IOVALITOTI STATE	coln Cremator 2-15-2	2004	Brentwood, MD
Baltimore,	permit. Departmine imports eny inju		21. Signature of Funeral Service Licensee	1 /			di Funeral Home, Inc
	205 g	_	23a. Part1. Enter the disease, or campical				lver Spring, MD 2090 Approximate
	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	Cardiovascular	_	Interval Detween
п	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):			
9289	cate b	dical	d				
O. Box 6	The law requires that the death certificate to the has been signed by the attending physionage 2 should be detached for use as the to a second the state of the tops of the to	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<b>a</b>	res that the de igned by the be detached	by Ph	Part II. Other significant conditions contri	buting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Records,	w require been sig should b	ted b				1 ☐ Yes	2 No 3 Probably 4 Unknown
ecc	alawra hasbe e 2 sh	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
alF						12 Yes 2	
Vital	ding Physician: n. After this certifications of the director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1 Inpatient 2 ER/Outpatie	Othor	me 5 ☐ Residence	ce 6 ☐Other (Specify)
Jo u		J: L	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	43	28d. Describe how	
sioi	Attending ir death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	296 Loanting (Com	et and Number or Rural Route Number,
Division	lor At after d Direct I in by	ertifi	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, ractory, office	City or Town,	
_	To the Hospital or Attence within 24 hours after death To the Euneral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowledge, dea r: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	744	29c. License number		. Date signed (Month, Day, Year)
	7-		Det Why	11/	OCME	F	EBRUARY 9, 2004
			30. Name and address of person who dom SUSAIN TO		.Penn Street, Baltin	more, Mar	yland 21201
Tr.	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 9 2004	32. Registrar's Signature	Sporks		

DHMH 17 Rev 1/2001

·S			Please	Type or Print in Black in	delible ink. Ensure	All Copies A	re Legible.	
A E	SCOBAR		_ For	State of Maryland / Depa	artment of Health and	d Mental Hygi	ene	
		•	1 - State Registrar	Cei	rtificate of Death	Rec	g. No. 2004	07029
			Decedent's Name (First, Middle, Las	t)		2. Date of Death		3. Time of Death
	Physici	an	Elsa Herrera Esc	char		Month FEB 1	Day Year 2004	0945 A M
	/Medic		4a. Facility Name (If not institution, give		th City Town or Location of De		4c. County of Death	
7	Examin	er	WASHINGTON ADVENT		4b. City, Town, or Location of De TAKOMA PARK	eatn .	MONTGOMER	
	Function		Social Security Number 6. S	ex 7. Age (In yrs. last birthday)	If Under 1 Year	rs. 8. Date of Birth	9. Birth	plece (State or Foreign ntry)
4	Funeral Director			□ M 2対 F 41 Yrs.	Months Days Hours M	in. (Month, Day, Oct. 15,	Year) Coul	
			Usual Residence of Decedent			1000. 15,	1702   Hex.	rco
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Man 4 sh	to	Maryland Prince	George's Hyattsvi	111e			1 ☐ Yes 2 📉 No
	288a	e C	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?
	with and	Funeral Director	1406 Kanawha Sti	reet Ant 102	20783		Morreloo	
	leath	era	11. Marital Status			(Specify Yes or No-	Mexico 14. Race - America	can Indian,
	ter o	ä	1 X Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 🔯 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White,	
36	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1⊠ Yes 2□ No Specify: Me	xican	Specify: Wh1	te
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dieal Examinat must be notilised at	ed	15. Decedent's Ed	ucation 16a Decer	dent's Usual Occupation	1 10	6b. Kind of Business/In	
15	in 72	olet	(Specify only highest gra	de completed) (Give	kind of work done during most of a DO NOT use retired)	working		,
12	within ene. then	Completed	Elementary/Secondary (0-12) None	College (1-4or 5+)	y Cleaner		Laundry	
0	Hygi ther int.		17. Father's Name (First, Middle, Last)			lame (First, Middle, Mi		
aŭ	ntal ed o	Be c	Carlos Herrera	Castellanes		lia Escoba		
2	should be filed within and Mental Hygiene.  I marked other than " umatic event, ine Mer	ဥ	19a. Informant's Name/Relationship (7		ng Address (Street and Number or			- Cadal
Maryland		1						
	other tre	i v	Manolo Rosales/ S	20b. Place of Dispo	6 Kanawha Street			
5	ages Intof H	11/1	20a. Method of Disposition 1	Removal from State	matory or other place)	-	Oc. Location - City or To	own, State
altimore,	Page ment		' 4 ☐ Donation 5 ☐ Other (Specify	Cludad in Cementer	io General	bruary 19 2004 Si	uchiate Chi	lapas, Modico
at	permit. Pages 1 Department of H Important: If Its any injury or ot		21. Signature of Funeral Service Licen-	500 0	2. Name and Address of Facility rancis J. Collin	s Funeral	Home Inc	
m	89 6 8 9		(inchen)	Hole 5	00 University Bl	vd. W., Si	lver Sprin	e.MD 20901
	3		23a. Part1. Enter the disease, or come	olidations that caused the death. Do not ent	er the mode of dying, such as card	liac or respiratory arres	it,	Approximate interval Between
	Physician		Immediate Cause (Final				1	Onset and Death
4	/Medical		disease or condition resulting in death)	a. OCCLUSINE PUCMO  Due to (or as a consequence of):	NARRY THROMB	OEMISOLISI	7	
100	Examiner				TUROMBOSIS			
		P.	Sequentially list conditions,	b. Due to (or as a consequence of):	MRDI DISCOI S			
	bed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	and and	xar	that initiated events resulting in death) Last	C. Due to (or as a consequence of):				
760,	be executed sician and burial-transit	aE						
687	death certificate b attending physic		•	d				
	death certificate e attending phys d for use as the	Physician/Medic	IF FEMALE:	23c. If yes, outcome of pregnancy			1	
Вох	ath c ttenc	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetel death 3	Ectopic pregnancy		23d. Date of delive Month	ery Day Year
		S	1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 ☐ 9 Unknown	Other (specify)			52,
P.O	at the de by the a stached	hy	9 ⊠Unknown					
	The law requires that the ate has been signed by the bage 2 should be detache	by	_	ontributing to death but not resulting in the ui	nderlying cause given in Part I.		cco use contribute to the	
rd	w require been signal		VIRAL INFECTI	0 N		1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	aw requ s been 2 shoul	Completed				24a. Was an	24b. Were auto	ppsy findings available
Re	The lav	E			<del> </del>	- autopsy performs	ed? death?	mpletion of cause of
a		Ö	25. Was case referred to medical		Of Place of C	1 🗷 Yes 2		2 No
5		O B	eyaminer?	Hospital: 1 ☐ Inpatient 2 R/Outpatien	Othor		1000	
of	Physical di	H- 1	27. Manner of Death	28a. Date of Injury 28b. Time of		28d. Describe how	ce 6 □Other (Specify	<i>V)</i>
uc	ding land.  After tuner	ion	1 ⊠Natural 5 ☐ Pending	(Month, Day Year) Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No		,,	
Si	or Attending itter death. Director: After in by the funer	ica	3 ☐ Suicide 6 ☐ Could not be			28f Location /Stre	et and Number or Rura	J Pouto Number
Division	after Direction by	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	eet, ractory, onice	City or Town,	State)	ii Addie Mallibel,
ш	urs aral l			<u></u>		telinence erece -		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	ysician: To the best of my knowledge, death liner: On the basis of examination and/or in-				
	To the within 2 To the complet	Jed	one)	and manner stated.	29c. License number	200	Data sianad (Maret	O V
	To Too	-	29b. Signature and title of certifier		O.C.M.E		f. Date signed (Month, 13.	2004
7	10		P anex		O.C.PI.E		TUD. TO,	2004
	10			completed cause of death (Item 23a) (Type,		auto and last a		
-			ANA RUBIC	111 Penr	Street, Baltim	ore, Maryl	and 21201	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Sporks			
	Registr	ar	FEB 1 7 200	4 pres	pour			

DHMH 17 Rev 1/2001

ORIGINAL

Physician

/Medical

Examiner

Directo

Funeral

Completed by

**Funeral** 

Director

7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Experies must be notified at

Department of Health and Mantel Important: if Item 27 is marked o any Injury or other traumatic eve

Pages 1 end 2 should be filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

resulting in death)	e. End Stage Kenal Di	Lsease		
	Due to (or as a consequ	ence of):		
_	Hypertension			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as e consequ	ence of):		
Cause (Disease or injury that initiated events resulting in death) Lest	Due to (or as a conseque	ence of):		
Part tl. Other significant conditions co	ontributing to death but not resulting in the unc	fertying cause given in Part I.		entribute to the cause of death?
Cardiomyopathy			1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 ☑ Unknown
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
			t□Yes 21XNo	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing I	Home 5 ☑ Residence 6 ☐ Oth	ner (Specify)
27. Menner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Piece of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier 1☑ Certifying Phy (Check only one) 2  Medical Exam	ysician: To the best of my knowledge, death o liner: On the basis of examination and/or inve and manner stated.	occurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause(s) and ma urred at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and fittle of certifier		29c. License number	29d. Date signe	d (Month, Day, Year)

State Registrar Raymond Bass M.D.

32/Registrer's Signeture

30. Name and endress of person who completed cause of death (Item 23e) (Type, Print)

3941 Ferrara Drive, Wheaton, MD 20906 ankal

D21340

February 16, 2004

	1	1- State of Maryland / E	Department of H Certificate of I	lealth and M Death	ental Hygie Reg.	ne 2004	07031
Physicia		1. Decedent's Name (First, Middle, Last)  Robert Milton Ford		-	2. Date of Death	Day Year	3. Time of Death 12:17pm
/Medio Examin		4a. Fecility Name (If not institution, give street and number) 1507 November Circle #403		Location of Death		4c. County of Death Montgom	
Funeral Director		302 48 4105 50	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11 19	9. Birthp Coun 53 Clev	eland, Ohio
Maryland s-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Md Montgomery Silv	n or Location ver Spring			1	0d. Inside City Limits 1 AYes 2 No
h with the 23a or 28a	al Direc	10e. Street and Number 1507 November Circle #403	10f. Zip Code 2090	4	10g.	Citizen of What Coun	itry?
partitioner, initially failed A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination in the incilling all once.	by Funer	11. Marital Status  1 Never Married 2 Married  1 Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
within 72 hou	mpleted	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired.  Lawyer	during most of work	ing	o. Kind of Business/Ind	Justry
uld be filed v fental Hygie rked other t	o Be Co	17. Father's Name (First, Middle, Last) Fred Cross	Lawyer		e (First, Middle, Maid ed L. Po		
i, Mally and 2 shou salth and M n 27 is mai ior traumal		Natalie L. Ford Daughter 1	. Mailing Address (Street a	riew Dri	ve #33 T	Coledo,Oh	nio 43615
Deficiency of the partment of Her mportant: If item iny injury or other page.		1 ♀ Bunial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify) Melm	Disposition (Name of ry, crematory or other place orial Gard	lens 02/	26/04 Cl		Ohio
Dermit Depart Impor any in		21. Signature of Funeral Service Licensee	5732 Ged	orgia Av	e NW Was	remation shington,	DC 20011
Physician /Medical		23a. Pert 1. Enter the/disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Checountscu				Approximate Interval Between Onset and Death
Examiner	er	Due to (or as a consequence					
icate be executed physician and sthe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence c. Due to (or as a consequence)	of):				
ath certificate attending physic ruse as the	√Medicai	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of delive	arv
tithe death by the atter	Physician/Me	In the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
necords, P.O. BOX of the law requires that the death certific a has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause give	en in Part I.		co use contribute to the	
The lay	Completed				24a. Was an autopsy performed	prior to cor death?	psy findings available mpletion of cause of
OI VICAL Physicien: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?  ↑★ Yes 2 No  Hospital: 1 Inpatient 2 ER/Ou	tpatient 3□ DOA Oth	0.55	h (Check only one)	e 6 □Other (Specifi	rel
UNISION OF VICE  To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ation: T	27. Manper of Death 28a. Date of Injury 28b.	Time of 28c. Injury	y at	28d. Describe how i		,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, S		
the Hosp in 24 hou the Fune	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	nd/or investigation, in my o	pinion, death occur	red at the time, date	and place, and due to	the cause(s)
T Mile Too	2	29b. Signature and title of certifier  W.C. (DME)	29c. Licens	e number		Date signed (Month,	
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	vius, 70.	C0951		
Sta Regist		31. Date filed (Month, Day, Year)  FEB 2 0 2004  32. Registrar's Signature	9 Sparks	/			

			For State Registrar	State of Marylar	•	artment of H			giene Reg. No. 20 (	04 07032
R,	Physicia	an	Decedent's Name (First, Middle)		_			2. Date of De. Month		3. Time of Death
	/Medic	al	ALBERT	FORTUNE	Jr.	45 Cit Town	Landing of Da	FERSILUI	4c. County of	04 9-12 AM
	Examin	er	4a. Facility Name (If not institution, Doctors Hosy	-		4b. City, Town, or Lanha		eatt)		e Georges
*	Funeral			6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Birt	h 9	Birtholace (State or Foreign
il.	Director		245-52-4372	¹ <b>X</b> ™ 2□F 65	Yrs.	Widitis Days	Tiodis W	Aug. I	7,1938	N. Carolina
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary Mary	tor	MD Princ	ce Georges	New C	Carrollt	on			1 <b>2</b> Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code	0.4		10g. Citizen of Wha	
	sath w	erai	6117 Lamont	Drive  12. Was Decedent Ever in U	15 12	207		/Constr. Van er ble	U.S.A	American Indian.
	fter de ritam iner i	by Funerai	11. Marital Status  1 ☐ Never Married 2☐ Marrie	ed 1 XYes 2 No 195	57-	Was Decedent of His If Yes, specify Cubar		erto Rican, etc.)	Black,	White, etc.
5-0036	d within 72 hours after death with the Maryland jiene. Than "natural", or Itams 23a or 28a-f ahow Ita Medical Examinat must be notified at		3 Widowed 4 Divorced	If Yes, Give Year or Dates: 198	36	1 ☐ Yes 2 🐼 No	Specify:		Specify:	Black
<u>.</u>		Completed	15. Decedent' (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired	furing most of v	vorking	16b. Kind of Busin	ess/Industry ment of
2121	filed within Hygiene. Ither then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		iler Att		-	The Na	
	the the	BeC	17. Father's Name (First, Middle, L					Name (First, Middle,		
Z	should be and Mental a marked o umatic eve	2	Albert Fort			_		sie Par		
Maryland	C1 10 7 10		19a. Informant's Name/Relationsh Lillie M. For			ng Address (Street a				
	s 1 and f Health item 27 other to		20a. Method of Disposition	20b. I		osition (Name of matory or other place		Date	20c. Location - Cit	MD 20734 y or Town, State
Ē	Page nent o nnt: #		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp	3 Linemoval from State		ional Ce	2	/19/2004	Laure	l , MD
Baltimore,	permit. Pages Department of the Important: If its any injury or of		21. Signature of Funeral Service L	icentee	22	2. Name and Addres	s of Facility	Snowden	Funeral	Home, PA
	00 5 6 0		220 Red L Enter the disease or	mplications that caused the deal						e,MD 20850
	Discolation.		shock, or heart fail re. List	only one cause on each the.	110	ter the mode or dying	y, such as card	nac or respiratory ar	1651,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Duetto (or as a consec	quince of):	MIA	\			
	Examiner		Sequentially list conditions	b. Myoca	ndia	L Just	ancti	an		
	Sit 9d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or all a consec	quence of):		8 8			
	al-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):					7
1,097	The law requires that the death certificate be execuled the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	cai		d						
¥ 68	ertifica ling ph e as th	Med	IF FEMALE:			·	<u> </u>			
Вох	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation of Live birth 2 Feta	aldeath 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
o.	at the de by the a stached	hysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	J64(1) 5 C					
S, D	res that igned b	by PI	Part II. Other significant condition	ns contributing to death but not res	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
ecords,	w require been signature should b							- 101	/es 2□No 3[	Probably 4 Unknown
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			25. Was case referred to medical				00 Plana - 4 F	1 Yes	20 No 10	Yes 2□ No
Ē	S S	o Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	ar	Death (Check only of Home 5 ☐ Resid	<i>ne)</i> ience 6 ⊡Other (	Specify)
Division of Vital	e e	on: T	27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at (?	28d. Describe t	now injury occurred	
Sio	Attending ir death. ector: After by the fune	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	not be One Place of Injury. At h	ome form at		res 2 □ No	286 Leasting /6	Street and Alumbay	or Court Don't March
<u>^</u>	after after Direct	Certification:	4 Homicide determi	28e. Place of Injury - At h building, etc. (Special	fy)	reet, factory, office		City or Tox		or Rural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifyin.	g Physician: To the best of my kno Examiner: On the basis of examina	owledge, deat	h occurred at the tim	ie, date and pla	ace, and due to the	cause(s) and manne	er as stated.
	the H hin 24 the F nplete	Medical	one)	and manner stated.	ation and/or in					
1		-	29b. Signature and title of certifier	1 House V	W	29c. License	200-7		29d. Date signed (A	O ( ) ( V) (
-	2		30. Name and ir is of person of	wh leted cause of death (Iter	m 23a) (Type.	Print)	200	>	41	4 207
_			JEFFREY J. Y	10NG M.D. 575	-	STREET	Su 177	35/ 4	AUREL M	0 20707
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 7	32. Registrar's Signa	ature &	Sparke	/			
6-	11091011				/	/ 3				

			1 - For State Registrar	State of Maryland		artment rtificate			ind Me		ene . No 2 () ()	և <u>07033</u>
	Physici /Medic		Andrea Paula Brancic   Estaura 10 000/   Estaura								- 11	
	Examir		4a. Fecility Name (If not institution, give					Location of			4c. County of I	Death
	Funeral Director		214-17-1705	ice- Casey Hou ix 7. Age (In yrs. I. ☐ M 2☑F 31	S e ast birthday) Yrs.	If Under 1	CKV1 Year Days	II e If Under 2 Hours	Min.	Date of Birth (Month, Day, Y	1070 -	mery Birthplace (State or Foreign Country) amaica
imore, Maryland 2121	h the Maryland r 28a-f show	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Frederi  10e. Street and Number		Town or Lo		Code			10g	. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 ☑ No If Country?
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. After other than "natural", or Items 23s or 28s-f show attle avent, the Marchell Examinar mant be millified at		1660 Wheyfield D: 11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		217 Was Decede If Yes, specifi	nt of His y Cubar	panic Orig , Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)	USA  14. Race - Black, V  Specify: B	American Indian, White, etc. lack
			15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give life. l	dent's Usual kind of work DO NOT use or Clie	done di retired)	uring most		16	b. Kind of Busin	
			17. Father's Name (First, Middle, Last)  Lloyd Francis		Selifo	or Cire		18. Mother	's Name (F	irst, Middle, Ma	iden Sumame)	earch
	es 1 and 2 should be of Health and Mental (Item 27 is marked (gother traumatic av		19a. Informant's Name/Relationship (7 Hermine Edmanson	ype, Print)				nd Number	or Rural R		ity or Town, Sta	te, Zip Code)
	dra in a go		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ace of Dispo imetery, crem e of H Cemet	sition (Name natory or oth Ieaven	of		Date Druar 200	y 23	c. Location - City	y or Town, State
Ball	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Licens	lenn	F1 50	ancis O Uni	J. vers	Colli ity E	lns Fu 31vd.	neral H W., Sil	ome Inc	ing, MD 20901
*	Physician /Medical Examiner		23a. Part1. Entèl Haè disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Metastatic  Due to (or as a consequ	Colon		, ,	, such as c	cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death Months
Division of Vital Records, P.O. Box 68/60,	*	ical Examiner										
	death certific e attending pl ed for use as t	Certification; To Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant af time of de 9□Unknown	death 3	Ectopic prec Other (spec					23d. Date of Month	delivery Day Year
	gned be de		Part II. Other significant conditions co							co use contribute to the cause of death? 2 № No 3 ☐ Probably 4 ☐ Unknown		
	hysicien: The his certificate h il director, page									24a. Was an autopsy performed	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA				heck only one) 5 □ Residenc	e 6 ⊠Other (	Specify) Hogy 1 a a
			27. Manner of Death  1 🖾 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Pes 2 No					injury occurred	nos, ice			
			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			office				t and Number o. itale)	r Rural Route Number,	
		edicai	29a. Certifier 1∑ Certifying Phy (Check only 2 ☐ Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at restigation, in	the time n my opi	, date and nion, death	place, and occurred a	due to the caus it the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
		Σ	b (h. / - trees a					Date signed (Month, Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	Sta Registr		Chitra Rajacopal 31. Date filed (Month, Day, Year) FFR 2 0 20	M.D. 1811 32. Registrar's Signati	Prin		Llip		e, #3	27, 01n	ey, Mo	20832

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 02-Year **Physician** 0815 AN Nannie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Cherry Lane Nursing Home Prince George's Laurel 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Sta Country)
April 27,1914 Virginia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2XX Months Hours Yrs 89 578.09.9943 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No MD Prince George's Laurel Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code U.S.A. 20708 9213 Briarchip Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? ↑ Yes 2 □ No WWII Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dental Hygienist Dentistry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be James Henry Schell Ada Conley 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9213 Briarchip Street Laurel, MD 20708 Janet Parker/ POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 2/27/04 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Juneral Service Licenses 5130 Wisconsin Avenue, N.W. WDC 20016 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** frontal Lobe Tumor Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medicai Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Intracere bral þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed XXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 135 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and menner steted. 29d. Date signed (Month, Day, Yeer) 29b. Signature end title 29c. License number 12 who completed cause of deeth (Item 23e) (Type, Print) 30. Name and eddress It Rd, Site U-15 College PEAK MI) 20740 OKWARA 6201 Greenhe IKechi 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State 20 **FEB** 2004 Registrar

07035 State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 19, 2004 6:00 PM James Matthew Ferrick, Sr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital Elkton ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpface (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F Yrs 78 Director 214-20-2630 January 17, 1926 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mayical Examiner must be notified at 1X Yes 2 □ No Directo Cecil E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 128 Castle Stone Drive 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status NT MY POICES?

No
If Yes, Give WWII

Year or Dates: Marines 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) Railroad Security 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill h and Mental H 7 is marked oth Be ျှ Daniel P. Ferrick Hazel G. Collier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is Mercedes Ferrick/Wife 128 Castle Stone Drive, Elkon, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of P
Importent: It ite
any injury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) A. Ferris & Co. 02/21/04 West Chester, PA 22. Name and Address of Facility notal Service Licensee 259 E. Main Street Andrew G. Gee 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Elkton, MD 21921 Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition vertualar 2 hours Physician today Condia resulting in death) /Medical Due to (or as a consequence of): **Examiner** Carchiny opotte Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Coraca physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical asi attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 √Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed 2**X** No certificate 1 Yes 2. No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elktun street ARROWS JUNC West 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 4 2004 Registrar

			1 - For State Registrar	State of Maryla		artment of H rtificate of L			Reg. No. 2U	04 07036	
	Physicia	n	Decedent's Name (First, Middle, Last,					2. Date of Dea	Day	3. Time of Death	
	/Medic		Herbert	Bertram	Goert		Leasting of Dogt	Februar	y 15, 20		
	Examin	er	4e. Facility Neme (If not institution, give		-11	4b. City, Town, or	_	1			
	Funeval		Montgomery Village 5. Social Security Number 6. Sec		rs. last birthday)		If Under 24 Hrs.	8. Date of Birt (Month, Da		Omery  9. Birthplece (State or Foreign	
	Funeral Director		121-22-9866	M 2□F	73 Yrs.	Months Days	Hours Min.	June 27	1930	New York	
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or Lo	ocation				10d. Inside City Limits	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23s or 28s-f show aumstic event, the Modical Examities in its be notified at	or.			,					1 ☐ Yes 2 🖾 No	
		Director	Maryland Montgome  10e. Street and Number	ГУ	Rockv	10f. Zip Code	.,,,,		10g. Citizen of W	hat Country?	
		Ī	1409 Kersey Lane			20854	4		United	States	
		Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	- 14. Race	- American Indian, , White, etc.	
စ္က		by Fu	1 ☐ Never Married 2 ဩ Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🛣 No			Specify:		
21215-0036	hours tural'	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus	White siness/Industry	
7	n na	plet	(Specify only highest grad	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)	rking		,	
212	filed with Hygiene other tha	Completed	Elementary/Secondary (0-12)	5+	Civ	il Servan	t		Departme	ent of Defense	
9	be file ntal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname	))	
Maryland	should to a Ment of marked umatic of	To	11012 0 211	Goertzel				Edith	O: T (	7-0-1	
Mar	12 sh h and 7 is rr traurr		19a. Informant's Name/Relationship (T)			ng Address (Street a					
ė,	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Dolores Goertzel/ 120a. Method of Disposition	Wife 20		Kersey L position (Name of matory or other place		Date ,		City or Town, State	
<u>o</u>	ages ant of nt: If if		1 ☐ Burial 2 XCremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State			,	17/2004	Alevand	ria, Virginia	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is sny injury or other trau once.		21. Signature of Funeral Service Licens			Name and Address		ACTIVITY OF THE PROPERTY OF THE PERSON OF TH	eral Hom		
Ö	P P P P P P P P P P P P P P P P P P P	W V	Michael	Muly	un 10	East Dee	er Park I	or., Gai	thersbur	g, MD. 20877	
· 京 ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・	Medical / Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final								
			disease or condition resulting in death)	a. Anorexia  Due to (or as a con	sequence of):						
		lner	O	b Cerebral V		Accident					
		Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):								
760,		cai E									
687	9 × 6			3.							
Вох	death certifica e attending ph id for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		□Ectopic pregnancy				of delivery	
	0 0 0		in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify)			Mon	th Day Year	
ords, P.O.	e law requires tha has been signed ye 2 should be de	Phy	9 ☐ Unknown  Part II. Other significant conditions co		reculting in the	underlying equipe gav	on in Part I	23a Did to	obacco use contri	bute to the cause of death?	
			Stroke	Titlibuting to death but not	-	, -	BIT III 7 GJE 1.			3 ☐ Probably 4 ☐Unknown	
		Be Completed						24a. Was	an 24b. W	/ere autopsy findings available	
Re			Hypertension						rmed? de	rior to completion of cause of eath? Yes 2 No	
on of Vital Record			Diabetes Mellitus 25. Was case referred to medical	<u>;                                    </u>			26. Place of De	1 ☐ Yes ath (Check only o			
	9 5	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1  Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	er: 4 🛭 Nursing F	lome 5 ☐ Resid	dence 6 Othe	r (Specify)	
	e fe		27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yee	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe I	how injury occurre	od	
Division	Attending or death. ector: After by the funer	Medical Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A	Al home, farm, st	reet, factory, office		28f. Location (3 City or Tox		r or Rural Route Number,	
Ö	ital or rs afte ral Dir led in										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)    Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							nner as stated. nd due to the cause(s)	
	To th To th comp		29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Month, Dey, Year)		
)	1		tur	M. M.D.		D 0	060552		February	16, 2004	
	1		30. Name and address of person who								
			Steven Fong, M.D.,	19703 Execu		-		town, MD	20874		
7.	Sta Registi		FEB 1 7 200		19	sparks	/				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 5:00 P M **FEB** 2004 11, GREEN MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CRESCENT CITIES CENTER RIVERDALE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Davs Months Hours 1 □ M 2X F MAY 3, 1911 VIRGINIA 92 Director 224-40-9397 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b, County rthan "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at 1 XYes 2 No NONE WASHINGTON D.C. Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number With 20018 U.S.A. 2404 10th ST. N.E. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic avent. the Medical Examena. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ Year or Dates: 3 Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DOMESTIC HOUSEWIFE 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KINDRED MARY KINDRED 2 FI.ETCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7504 ELBROOK CT., LANHAM, MD. 20706 ADELL PEEBLES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury or 1 ■ Burial 2 Cremation 3 Removal from State EMPORIA, VA. FOREST LAWN MEM. GARDENS 2-16-2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Zicensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Chame M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE /Medical Due to (or as a consequence of) **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 3 ☐ Probably 4 X Unknown SEVERE DEMENTIA 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 2□ No 1 ☐ Yes 2X No 1 Yes funeral director. 26. Place of Death (Check only one Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Menner of Death 28b. Time of After Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeref Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospitef 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific FEB. 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING ST. #214, SILVER SPRING, MD. 20910 NEGUSSIE, YEHEYIS M.D. 1111 32. Registrar's Signature 31. Date filed (Month, Day, State racket FEB 17 Pener Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:25A FEBRUARY 12,2004 GREENBLATT VIOLA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY **BETHESDA** SUBURBAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 X F SEPT. 12, 1915 WASHINGTON DC Director 88 579-09-8137 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location il Hygiene. other than "natural" or items 23e or 28e-f ehow vent, the Medical Evantinat the notified at 10a. State 10b. County 1 XYes 2 ☐ No Director BETHESDA MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **#510** 20852 UNITED STATES OF AMERICA 10301 GROSVENOR PLACE by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER permit. Pages 1 and 2 should be filed w
Department of Heelth and Mental hygies
Important: If item 27 is marked other it
any injury or other traumatic event, in
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NATHAN FRIEDENBERG SOPHIE BLASER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) **#510** NATHAN GREENBLATT - HUSBAND 10301 GROSVENOR PLACE BETHESDA, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL 02/13/04 FALLS CHURCH, VA 22. Name and Address of Facility
EDWARD SAGEL FUNEBAL DIRECTION; INC
20852 21. Signature of Funeral Service Licensee 23a. Part 1. Series the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute ischemic days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical 38 attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 0 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 212No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide NO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier men D0058960 20 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Center Drive, Room B1 D733, Bethesda, 10 20892-1063 Jason W. Todd, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks FEB 17 2004 Registrar

Greenblatt

iola

DAVID See Goodman

## VOID

# CERTIFICATE #

2004-07040

## SEE

CERTIFICATE #

2003-44438

State of Maryland / Department of Health and Mental Hygiene? 0.01.

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		-	For State Registrar	State of W	C C	ertificate of	Death		1. No.	4 0/041
	Physici		1. Decedent's Name (First, Middle, I	Last)			2	2. Date of Death Month	Dey Ye	3. Time of Death
	/Medic	al	011-17-	ckett				ebruary	17 200	
	Examin		4a. Fecility Name (If not institution, g				r Location of Death		4c. County of C	
			Casey House of 5. Social Security Number 6.	Montgomery Sex 7. As	County ge (In yrs. last birthdo	Rockv		. Date of Birth	Montgom	Birthplace (Stete or Foreign
	Funeral Director		212-72-6000 Usuel Residence of Decedent	1□M 2∏ F	44 Yrs	Months Days	Hours Min.	(Month, Dey, ) March 19	(ear)	Country) Maryland
	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary F-f ●h	į	MD Montgo	mery		Germanto	wn			1 Yes 2 □ No
	th the	irec	10e. Street and Number			10f. Zip Code	00076	100	g. Citizen of Wha	Country?
	23a c	al	19133 Wheatfield				20876		Jnited S	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury of other traumatic event, the Medical Examinal must be invitited at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1  Yes 2 X If Yes, Give Year or Dates:		3. Was Decedent of F If Yes, specify Cub  1 ☐ Yes 2 ☒ No	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)		umerican Indian, Vhite, etc. Black
5	72 ho natur dical	Completed	15. Decedent's (Specify only highest of	Education grade completed)	) (G	cedent's Usual Occupive kind of work done	during most of working	16	6b. Kind of Busine	ess/Industry
2	Aithin han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	a. DO NOT use retire A.D.D. Des			Surveyi	no
7	iled v Hygie ther t		17. Father's Name (First, Middle, La	2	0	4.D.D. Des	18. Mother's Name (	First, Middle, Ma		6
and	d be f antal l	o Be	Andrew Sewell Sr				Ernestine		,	
<u> </u>	should nd Me mark matik	유	19a. Informant's Name/Relationship		19b. M	ailing Address (Street	and Number or Rural I	Route Number, (	City or Town, Star	e, Zip Code)
	nd 2: alth ai 27 is rrtrau		Brian J. Hacket	t Sr./ Hus	band 191	33 Wheatfi	eld Drive,	German	town, MD	20876
ře,	s 1 a of Hea Item		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	ce) Dai		Oc. Location - City	
Ē	Page In a page		1 Burial 2 ☐ Cremation 3  1 Donation 5 ☐ Other (Spe		Gate of		Februa 2004	ry 21 S:	ilver Sp	ring, MD
Baltimore,	permit. Departr Importa		21. Signature of Funeral Service Lice	Huve			ess of Facility DeV , Gaithers			, 10 East De
	No.		23a. Part1. Enter the disease, or co shock, or heart ailure. List or	omplications that cause ily one cause on each	d the death. Do not line.	enter the mode of dyi	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Leiom	yosarcoma					Onset and Death 4 Years
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):					
R	Lxammer	_	Sequentially list conditions,	b. — Due to /or as	s a consequence of):					-
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury	Due to (or as	a consequence or,					
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a consequence of):					
68760,	e be e siciar siciar	alE		d						
68	tificate be executed g physician and as the burial-transit	edical								
.O. Box	death cer e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year
<u>a</u>	The law requires that the ate has been signed by thogge 2 should be detache		Part II. Other significant condition	s contributing to death	but not resulting in th	e underlying cause giv	ven in Part I.	23e. Did toba	icco use contribut	e to the cause of death?
ds,	uires n sign	d by						1 🗆 Yes	2 X No 3	Probably 4 Unknown
Records,	w requir	Completed						24a. Was an	24b. Were	autopsy findings available to completion of cause of
Re	The lav	E O		-				autopsy performe	ed? prior deat ΩNo 1 □	h?
Vital		0	25. Was case referred to medical				26. Place of Death /			
>	is d	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1  Inpat	ient 2 ER/Outpa		ner: 4 🗆 Nursing Home	e 5 ☐ Residen	ce 6 X Other (	Specify)Hospice
n of			27. Manner of Death 1 TNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. Tim ay Yeer) Inju	y Wo		d. Describe how	injury occurred	
sio	tent featl for: the	cati	2 Accident investiga 3 Suicide 6 Could no	the	AA b 4		Yes 2 □No	If Location /Stra	and Alumbar a	Cural Couta Number
Division	or Attendate death Director:	Certification;	4 Homicide determin	ad 286. Place of it	njury - At home, farm. etc. (Specify)	street, factory, onice	20	City or Town,		r Rural Route Number,
<b>ш</b>	Hospital A hours Funeral ely filled	edical Ce	29a. Certifier 1X Certifying (Check only one) 2 Medical Ex	Physician: To the best caminer: On the basis and manner s	t of my knowledge, d of examination and/o	eath occurred at the ti r investigation, in my o	me, date and place, an opinion, death occurred	d due to the cau I at the time, dat	ise(s) and manne e and place, and	r as stated. due to the cause(s)
	To the l within 2 To the l complet	Med	29b. Signature and title di certifier			29c. Licens	se number	290	d. Date signed (M	onth, Dey, Year)
)	FSFO		· -     / _	1		D35	635	F	ebruary	17, 2004
	12		30. Name and address of person will Joseph Kaplan,	ho completed cause of	death (Item 23a) (Ty	pe, Print)	ville MD	20855		
			Joseph Kaplan,  31. Date filed (Month, Day, Year)		trar's Signature					
	Sta Regist		FEB 1 9		A Signature /	Spork				

			1 - For State Registrar	State of M	arylanı	-	artmen rtificate			and M		Reg. No. 2	001	
1	Physici /Medi	al	1. Decedent's Name (First, Middle, Last  John Allen	Haigh			4h Ciby	Tours or	Location o	of Dogsth	2. Date of De Month Februa:	ry 14,	Year 2004 by of Death	3. Time of Death 10:20 AM
	Examir	er	4a. Facility Name (If not institution, give 9513 Brunett Ave	nue			Si	lver	Spri	ng		Mo	ntgom	nery
	Funeral Director		5. Social Security Number 6. Se 579-12-1488  Usual Residence of Decedent	x	81	ast birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	(Month, De Oct. 2	th Year) 1922	9. Birth Cou W.	nplace (State or Foreign untry) ashington, D
	e-f show	ctor	10a. State 10b. County  Maryland Montgor	nery		Town or Lo		5						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	h with th	ai Dire	10e. Street and Number 9513 Brunett Aver	nue			10f. Zip		20901			10g. Citizen of Unite		
036	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-f show he Medical Evaminar must be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or No Rican, etc.)	Spec	ack, White	ican Indian, b, etc. White
Maryland 21215-0036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or othar traumatic event, the Medical Evandrat must be notified at ODGs.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad		5+)	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us atent	Occupa tk done d te retired Drat	ation <i>Juring</i> most Etsmai	of worki	ing	16b. Kind of I	Business/l	-
yland	ould be filed Mental Hyg arked other attic event,	To Be C	17. Father's Name (First, Middle, Last)  Edward Hai	gh					18. Mothe Gra		Frye	, Maiden Suma	тө)	
	and 2 sho eith and 27 is m		19a. Informant's Name/Relationship (T) Ruth Pauline Ha		e)	19b. Mailir 95.	g Address L3 Bri	(Street a	nd Numbe t Ave	ror Rura ••• S	ilver S	er, City or Town Spring,	Md •	p Code) 20901
Baltimore,	Pagas 1 a ment of Ha ant: If item ury or otha		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		CE	ace of Dispo emetery, cren esapeal	natory`or ol	ther place	ory F	ebru	ary 17	20c. Location Belt		own, State .e., Md.
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licens	There is	Un 120	22	Rapp 933	Addres Fund Gist	s of Facility eral Ave.	and Si	Cremati	ion Serv	vices	0910
*	Physician /Medical		23a. Part. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Conges	tive	Heart	er the mode	e of dying	, such as	cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death Year
8760,	Examine and he burial-transit	dical Examiner		Due to (or as  Arteri  Due to (or as  Due to (or as	oscle a consequ	erotic mence of):	Hear	t Di	sease					15 Years
P.O. Box 6	the death certifica y the attending pl ichad for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre						ate of deliv	very Day Year
	w requires that the de baan signad by the a should be detachad f	by	Part II. Other significant conditions co Sprue and Mala				nderlying ca	use give	n in Part I.					the cause of death?
Il Records,	Tha law recata has bar	Completed	Asthma		·			<u>-</u>			24a. Was autor perfo	osy ermed?	Were autoprior to codeath?	opsy findings available ompletion of cause of
Division of Vital	ting After	tion: To Be	25. Was case referred to medical examiner?  1	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nur	sing Hor		one) dence 6 ⊡Ot now injury occu		(y)
Divis	tal or Attenders safter daath sal Director: ad in by the	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Inj building, et	ury - At hor c. (Specify,	me, farm, str	eet, factory,	office		3	28f. Location (S City or Tox		ber or Run	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Medical Exami	sician: To the best ner: On the basis of and manner sta	of my knov f examinati ated.	vledge, death ion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a h occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as s and due t	itated. o the cause(s)
ł	To th Within Comp	Me	29b. Signature and title of certifier	Tengo	told	und		D121				29d. Date signe Febru		Day, Year)
			30. Name and address of person who or George Sengstac	k, M.D.;	3929	Ferrar		, Wh	neator	n, M	d. 2090	16		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 9 200	32. Registr	ar's Signat	y A	do	utis	1					

State of Maryland / Department of Health and Mental Hygiene	2	0	0	4	0	7
0 "" 1 (5 "				•	-	

			1- For State of Maryland / Registrar	Department of Health and I Certificate of Death	Mental Hygier	ne 2004 07043 No.
	Physici /Medic		Decedent's Name (First, Middle, Last)     CHAMP HENRY HALL		2. Date of Death Month	Day Year 1 - 48 AM
*	Examir		4a. Facility Name (If not institution, give street and number)  5t. Agnes Health Coll	4b. City, Town, or Location of Death Bolt, more	_	4c. County of Death
	Funeral Director		5. Social Security Number  227-18-0453  Usual Residence of Decedent  6. Sex  1 M 2 F 7. Age (In yrs. last bigger)  7. Age (In yrs. last bigger)	Months Dave House Min	Apr. 4, 191	9. Birthplece (State or Foreign Country) Virginia
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Tow Maryland Prince George's Greenk			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	ai Director	10e. Street and Number 59K Ridge Road	10f. Zip Code 20770		Citizen of What Country? United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28e-1 show important: if Item 27 is marked other than "natural", or Itams 23e or 28e-1 show are injury or other traumatic event. The Medical Examinar must be routiled at ance-	by Funerai [	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (St. If Yes, specify Cuban, Mexican, Puero	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 housing. Ithen "neturalise is Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation     (Give kind of work done during most of work iffe. DO NOT use retired)	king	. Kind of Business/Industry
and 2	ld be filed v ental Hygie kad other t ic event, III	To Be Co	17. Father's Name (First, Middle, Last) Bluford Hal		Se (First, Middle, Maid	elf employed <sup>(en Sumame)</sup> McDaniel
Maryland	ind 2 shoulaith and Mississipped 27 is mark	-		b. Mailing Address (Street and Number or Ru. 388 Glenmore Avenue E		
Baltimore,	Pages 1 and nent of Hearing: If item		1 Rurial 2 Cramation 3 Permoval from State Cemete	of Disposition (Name of ary, crematory or other place) ge Washington Cem. 2/1		Location · City or Town, State
Balti	Departm Departm Importal any inju		21. Signature of Funeral Service Licenship	22. Name and Address of Facility Donald V. Borgwardt 4400 Powder Mill Rd	Funeral H	ome, P.A.
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	not enter the mode of dying, such as cardiac attal. Infatation	or respiratory arrest,	Approximate Interval Between Onset and Death MTNUTES
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or consequence)  Due to (or as a consequence or consequence)  Due to (or as a consequence)	ety disease		Years
.O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
S, P	quires that t n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
al Record		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Division of Vital	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	ation; To Be		Other	th (Check only one) ome 5 Residence 28d. Describe how inj	
Divis	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		City or Town, Sta	
	To the Hospitel or within 24 hours afte To the Funeral Dirr completely filled in I	Medical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)
}	Twit o	-	29b. Signature and title of certifier physician	29c. License number 52544		nate signed (Month, Dey, Year)  Trucky 15, 2004
	×3	to	30. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)  130. Name and address of person who completed cause of death (Item 23a)	(Type, Print) George Rd #204	, Catoni	The UND 21228
	Registr		FEB 1 8 2004 Denurar	B sporks		

DHMH 17 Rev 1/2001

Champ H. Hall

Sacqueline Hugher

## VOID

# CERTIFICATE #

2004-07044

## SEE

**CERTIFICATE** #

2003-44485

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 7,2004 **Physician** Feb. 9:15 PM MAROUIS PERRY HUDSON /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 XM 2 ☐ F 71 May 6, 1932 Delaware Director 222-18-5474 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 1200 Calebs Way USA 12. Was Decedent Ever in U,S. Armed Forces? 1 12(Yes 2 □ No If Yes, Give Year or Dates: Korea Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married white 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced HUDSON 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Broadcast Engineer Public Television MARQUIS PERRY timore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hester Ellen Davis Marquis Leroy Hudson 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health en Item 27 is i Nancy Hudson/wife 1200 Calebs Way, Salisbury, MD 21804 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Depertment of Important: If It any Injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Wicomico Memorial Park 2/11/04 Salisbury, MD <sup>22</sup>, Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 e of Funeral Service Lice Approximate Interval Between Onset and Death Enter the disease, or complications that caused the de, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical oncumoruse **Examiner** Due to (or as e consequence of) Physician/Medical Examiner Physician: Tha law raquiras that tha death certificate be axecuted To the Funeral Director: After this cartificate has been signed by the attending physicien and completely filled in by the funeral director, paga 2 should be datached for usa as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? consin's pisease l or Attending Physician: Tha law after death.

Director: After this cartificete hes? 1 Tes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 30 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of + Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date sigged (Month, Day, Year) 29b. Signature and title of certifie 04 D3085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rayo 1346 S. Division St. Suite, Salisbury, Md. 21804 32. Redistrar's Signature State 2004 Registrar

Please Type or Print in Black indelible lnk. Assure All Copies Are Legibie.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200<sup>Year</sup> 1:35 AM Feb. 27, Jordan Mary Lou /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Co. General Hospital Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 72 212-28-9555 Director April 28, 1931 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location the Medical Examinar must be notified at 1 □Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 Bollinger Road USA Completed by Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages's' and 2 should be filed within ment of Health and Mental Hygiene.
ant: If item 27 is marked other than 'ury or other treumatic event, Inc. Me Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Graham Roland Cranston, Sr. Margaret Hazel Stran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages vi and Department of Health Important: If item 27. any injury or other trugones. Edward Lee Jordan/Husband 1810 Bollinger Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 2004 Freeland, MD 21. Signature of Fureral Service Licer's 22 Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or con lition resulting in death)

24 Second St., New Free or 24 Second St., New Freedom, PA Pnysician 2 weeks /Medical Due to (or as a con sequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ alure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 240. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) /2 DX6 Medical Certification; To 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Mann y of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death I Director: A id in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funerel D

completely filled in To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier D0059943

Registrar

State

ORIGINAL

Stoner ave Suite 307

30. Name and address of pers at the completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Apel

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 () 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** bruan /Medical 14. Pacility Name (If not institution, give st Town, or Docation of Death 4b City Examiner 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Days Director NONE Usual Residence of Decedent 10d. Inside City Limits death with the Marylend 10b. County 10c. City, Town or Location 10a State ?7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Extrainer mast be notified at 1 Yes 2 □ No MONTGOMERY Directo DAITHERS BURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 22 No Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NFANT permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be INKNOWN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WOTHER NORTH 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund at 2 price Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Cleans or injury Examine The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 22No 1 ☐ Yes 3 Probably 4 □Unknown cate has been significant categories categor 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2.2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other. ٩ 1 🖂 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27 Manner of Death Certification: 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mental)

32 Registrar's Signature

**ORIGINAL** 

	-	For State Registrar		Certificate of D	Death	Reg. No	2004	0/04
		1. Decedent's Name (First, Middle, Last	0		-	Date of Death     Month Da	ay Year	3. Time of Deat
Physici		GERRY	D. JOYN	ES			8 2004	0400
/Medic		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	40	c. County of Deatl	h
		28927-MANOKINI	FAIRMONT RD.	MA	NOKIN	) [	SOMER	SET
Funeral		Social Security Number     6. Se	7. Age (In yrs. last birt	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	nplace (State or For untry)
Director		×14-62-1141	RM 20 F 49	Yrs.		10-22-5	4	MD.
	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Towr	n or Location		<del> </del>		10d. Inside City Lie
S T	٦							1 ☐ Yes 2
98-1	Director	10e. Street and Number	RSET INI.	ANOKIN 10f. Zip Code		10a C	itizen of What Co	untry?
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Department of Health and Mental Hygiene. Importent; or Items 23a or 28e-f show importent: If item 27 is marked other than "neturel; or Items 23a or 28e-f show yinjury or other treumatic event, the Medical Ever there must be notified at some	Funeral	2872 1-11/HNOKI	12. Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	rican Indian.
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oorte vinju		21. Signature of Euneral Service Licen-	see	22. Name and A. dress	s of Facility B	ENNIE Sn	11TH FI	H
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is certificate has director, page 2		2 Accident investigation		non attack factors office		28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
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fter death. <b>Director:</b> After this certificate has in by the funeral director, page 2	Certification: T	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	building, etc. (Specify)	e, death occurred at the tim				
fter death. <b>Director:</b> After this certificate has in by the funeral director, page 2	edical Certification: T	2 Accident 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)	building, etc. (Specify)	e, death occurred at the timed/or investigation, in my op	oinion, death occur	red at the time, date ar	nd place, and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPH KADISH FEBRUARY 10 2004 1:15A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HOSPICE - CASEY HOUSE ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV. 19, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**▼** M 2□ F 88 217-16-1941 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at MARYLAND MONTGOMERY 1 TyYes 2 □ No ROCKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5901 MONTROSE ROAD 20852 by Funeral UNITED STATES OF AMERICA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII NAVY Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natursi" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) HEALTH EDUCATOR GOVERNMENT 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 SAMUEL KADISH Pages 1 and 2 should LENA SAVAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: if item 27 any injury or other to once. SYLVIA KADISH - WIFE 5901 MONTROSE ROAD, ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL GARD. 02/12/04 FALLS CHURCH, VA 21. Signature of Funeral Service Licenses LOWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part4 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** METASTATIC PROSTATE CANCER YEARS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 No 3 Probably 4 Unknown Completed page 2 should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 20 No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 Tes 2 No the 2 Accident To the Hospital or Atteni within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Cneck only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD42452 FEBRUARY 10, 2004 30. Name and address of person who campleted cause of death (Item 23a) (Type, Print) DR. CHITRA/RAJAGOPAL, MD 18111 PRINCE PHILIP DRIVE, # 327, OLNEY, MD 20835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Docker FEB 1 7 2004 Registra

			For State Registrar	State of Marylan		artment of rtificate of		_	giene Reg. No. 20 (	07050
	Physici		Decedent's Name (First, Middle, Last)     DON CALV		AN			2. Date of De 2 Month 0		year 2210 M
	/Medic Examin		4a. Facility Name (If not institution, give Dorchester C  5. Social Security Number 6. Sec	seneal Hospi				s. 8. Date of Bin		f Death  HE STER  9. Birthplace (State or Foreign Country)
	Funeral Director		214-68-5663 X	M 2□F 49	Yrs.	Months Days	Hours Min		15, 1955	Maryland Maryland
	e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Dorch		y, Town or Lo ienna					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number			10f. Zip Code	0		10g. Citizen of Wh	nat Country?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural; or items 23e or 28e-f show or other fraumatic event, the Medical Exter invertinat be notified at or other fraumatic event, the Medical Exter invertinat be notified at	by Funeral	208 Market Street  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pue	Specify Yes or No arto Rican, etc.)		- American Indian, , White, etc. White
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	and 2 should be ealth and Mental n 27 is marked er traumatic ev		19a. Informant's Name/Relationship (Ty April B. Kirwan/w	ife	208	Market		nna, MD 2		
nore	Pages 1: nent of He int: If iten iry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □   '4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre	osition (Name of matory or other pl Memory Ca	ace) indens: 2/	Date	20c. Location - C	Dity or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licent	-	2	2. Name and Add Holloway	ress of Facility Funeral	Home Pro		al Association
	rate be executed xysician and hysician and the buriat-transit the buriat-	l Examiner	if any, leading to immediate cause. Enter Underlying Causa (Disease or injury	Due to (or as a consect.   ence of):	lery ]	Dz			Interval Between Onset and Death	
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d	al death 3	⊒Ectopic pregn <i>ar</i> ⊒ Other (specify)	су		23d. Date Mont	o of delivery th Day Year
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Division of	Attending Physic death. sector: After this by the funeral di	tion; To	27. Mannerof Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. In		-	how injury occurre	
Divis	를 를 를 드	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, si	treet, factory, offic	е		Street and Numbe wn, State)	r or Rural Route Number,
	ne Hospitel n 24 hours a ne Funeral (	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and man date and place, ar	iner as stated. nd due to the cause(s)
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0			50. Name and address of person who de	ompleted cause of death (Ite	m 23a) (Type	e 03 5	alisbun	1 MD Z	1804 C	itchell sittelman, DC
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Fune Direct			236-32-6		1E M 2	2□ F	7. Age	81	Yrs.	Months		Hours		12/20	/19	ar) 22	9. Birthi Cour WV	ntry)	or r Grolgir
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			23a. Part1. Enter shock, or hea	the disease, or art failure. List	r complication	ns that o	caused t	he death. I	Do not en	ter the mo	de of dyin	g, such a	s cardiac	or respiratory	arrest,			Approxima Interval Be	tween
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Euneral Director: After this certificate has been signed by the attending physician and the last think is the the formed director. After this certificate has been signed by the attending physician and the last think is the the formed director.		Physician/Me	23b. Was deceded in the past 12 1 Yes 2 9 Unknown	2 months?	1 4	Live	birth 2 nant at ti	f pregnancy : Fetal de ime of death	ath 3	⊒Ectopic p ⊒ Other (s							Date of deliver	-	Year
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Y	/Media	cal	4a. Facility Name (If not institution, giv	to ctroot and number)	gsdon		b. City. Town, o	Jan 15 or Location of Death		1:45 p	<u>m</u>
-	Examir	ner	Cumberland Nursi		<b>,</b>	Cumberla			Allega		**
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	1 en Heal		Robert Reinhart  20a. Method of Disposition	attorr	20b. Place of Disp	S. Centre		Date		City or Town, State	1002
mor	Pages ent of nt: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		St. Patrick	ematory or other plac s Cem	e)	1/20/2004		Savage	MD
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			30. Name and address of person who	HALM	105 3		legst	- Cu	uberl	y 16,20 and, Vld	4500
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07053 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 Month **Physician** 02 09 2004 BERTHA GRAHAM LONG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO SALISBURY 129 HOLLAND AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day. 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F 02-29-1912 MARYLAND 91 **Director** 214-22-3785 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "netural", or Items 23s or 28s-f show tre Medical Examiner must be notified at 1 XYes 2 No SALISBURY WICOMICO Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 129 HOLLAND AVENUE death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atler Department of Healin and Mental Hygiene. Important: If item 21 is marked other than "natural; or ite any injury or other treumatic event, it a Medical Examins 1 Never Married 2 Married 1 ☐ Yes 2⁄ ☐ No WHITE Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED REGISTERED NURSE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PETER GRAHAM CHRISTIA MAJORS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM P. LONG, JR. - SON 51 FOX HILL DRIVE, SOUTHAMTON, NEW JERSEY 08088 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ST.STEPHENS CEMETERY 02-13-2004 DELMAR, DELAWARE \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral/Service Licenses 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performi 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 2 No certificate 1☐ Yes or Attending Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို After the funeral 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? ical Certification: 1 Natural 5 Pending the Funerel Director: Af 1 ☐ Yes 2 ☐ No М investigation 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29b. Signature a 2/11/04 who completed cause of death (Item 23a) (Type, Print) 100 E Carroll St. .0

State Registrar

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760.

Division of Vital

31. Date filed (Month, Day, Year) FEB 1 3 2004 32. Registrar's Signature

& Sparks

		For State Registrar	State of Maryland	/ Depa		lealth and	Mental Hygi	ene g. No. 200	
Physici		1. Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat		4c. County of De	
			19 1- Retrub		Salusba			Wicomi	
Funeral Director		5. Social Security Number 6. Se 215-36-1687	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, November		ithplace (State or Foreign Sountry) Maryland
anyland show	_	10a. State 10b. County	10c. City, To						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the Marities	recto	Maryland Somers  10e. Street and Number	ec	CFI	sfield 101. Zip Code		10	g. Citizen of What 0	AT .
h with	aiD	329 Somers Cove Ap	artments			21817		U.S.A.	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Medical Exartirar must be notified at	y Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give		Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
atural' cal Ex	ted by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	6a. Deced	ient's Usual Occup	ation	1	6b. Kind of Busines	
within 7; ene. then n	Completed	(Specify only highest grad	College (1-4or 5+)	(Give life. I SSEM	kind of work done OO NOT use retired	during most of word)	rking		
Hygin ther		17. Father's Name (First, Middle, Last)			OTÀ	18. Mother's Nar	ne (First, Middle, M	Paint Brus Maiden Sumame)	sn Mrg.
and Mental Hygiene. is marked other than sumatic event, the M	To Be	John Brumley				Eva Swi	.ft		
1 1 1 1 1 1		19a. Informant's Name/Relationship (T)  Vonda Lee Morgan			•		ral Route Number, Salisbury	City or Town, State,  MD 218	
Health item 27 other tr		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other place			0c. Location - City o	
artment of lortant: If its injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	removal from State		Memorial Pa		./04	Crisfield,	MD
Department of Health Important: if item 27 any injury or other to once.		21. Signatur of upral Service Licens  Robert H. Brad	shaw, Jr	_ B:	Name and Addrest Nadshaw 8 06 W. Maj	Sons Fu	neral Hom Crisfield	ne 1, MD 218	317
Inysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a.  Due to (or as a consequence)	ce of):	Preumo		or respiratory arre	St,	Approximate Interval Between Onset and Death
ate be executed nysician and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disass of thus) that inditated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  d.						
ste has been signed by the attending phy page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
signed d be de	by	Part II. Other significant conditions con	ntributing to death but not resulting	g in the ur	derlying cause give	en in Part I.		/	o the cause of death?
page 2 shout	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		2 2 10
fter this oneral dir	2	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	lospital: 1   Inpatient 2   ER/0 28a. Date of Injury (Month, Day Year)   28b	Outpatien  Time of Injury	28c. Injun Worl	/ at	ome 5 Residen 28d. Describe hov	ce 6 Other (Spering occurred	ecity)
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
24 hours a Funeral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	lge, death and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mon	th, Day, Year)
		2 he rah			Dos	51359 .	ţ	chowing ?	ig The Done
5		30. Name and a ress of person who co	ompleted cause of death (Item 23a	SAU	Print) Usha	Natesan, MD 760	M • D •	7	,,,,,
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		Acost.	AT			

State of Maryland / Department of Health and Mental Hygiene 2001 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna Isabell Murphy 27, February 2004 8:55 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner College View Center Frederick Frederick If Under 1 Year
Months Days 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 191 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Min. Hours 213-50-1179 85 Director 1918 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 10802 Cook Brothers Road 21754 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No λq If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ns eny injury or other traumatic event, the Medit once. Elementary/Secondary (0-12) College (1-4or 5+) self home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Francis Stanley Murphy Ruth Elizabeth Wilcom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David I. Roderick, nephew 10435 Dublin Road, Walkersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 3/1/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licenses M00999 106 East Church Street, Frederick, MD 23a. Part | Enjer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASCVD **Physician** 541 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) Examiner the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 Yes 2 PNo 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an has autopsy performed this certificate 2 PNo or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours after use..... To the Funerel Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide the Hospitel 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 2 Medical Examine 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Dey, Year) D-31912 mi 10115007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1564 OPOSJUMTUWN PIUS MENOCAL, ND. mEDERICH MD JULID 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

MAR 08

2004

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 07056 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Charles McDonald Feb 25, 2004 Sr. 5:30am <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 213 Allendale Avenue LaVale Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr 29, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 OH **Funeral** Days Hours 1**√** M 2□ F Min 214-32-3725 Yrs Director 72 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow the Medical Evartiner must be notified at WV Morgan Great Cacapon 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Oliver Lane 25422 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S.. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1√Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white δ 3 ☐ Widowed 4 ☐ Divorced 1948-1952 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Foreman **B&O** Railroad permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Importent: If Item 27 is marked other tl
any injury or other treumatic event, Item
ONCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Archie McDonald Hazel Malcolm McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann McDonald wife P.O. Box 2181 MD 21502 Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery; crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 3/1/2004 MD ' 4 □ Donation 5 □ Other (Specify) Flintstone 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CANCER OF THE LUNG 6 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the attending property detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> CAVITARY PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No ATRIAL FIBRILLATION has page CHRONIC OBSTRUCTIVE AIRWAYS DISEASE certificate 1□ Yes 2☑No or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) name examiner? 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After Natural 5 Pending déath. М 1 ☐ Yes 2 ☐ No investigation s after déath 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Hospitel within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier D54765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 Seton Drive Cumberland MD 21502 Robert Rapp M.D. 32. Registrar's Signature State MAR 0 8 2004 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 4

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	1	= For Unpend ITem#23a Registrar		æa-1,Per MF,€	rtificate of L	eath	Rag	ı. No.	
Physician /Medical		<ol> <li>Decedent's Name (First, Middle, L. JAS)</li> </ol>	ast) ON ROBERT	MOORE			2. Date of Death Month FEB . 2	Day Year 2004	3. Time of Death
Examiner		4a. Facility Name (If not institution, gi FRANKLIN SQUARE		)	4b. City, Town, or ROSEDA			4c. County of Deeth BALTIMOR	E
Funeral Director		174-54-6402	Sex 7. A 1 M 2 □ F	ge (In yrs. last birthday, 28 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y MAY 1, 1	(ear) 9. Birthp	place (State or Foreigntry)
show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L				1	0d. Inside City Limit
death with the Maryland ms 23a or 28a-f show routed to routified at	1	MARYLAND   CECIL 10e. Street and Number		RISING	SUN 10f. Zip Code		10g	J. Citizen of What Cour	
F F E		72 MOORE FARM Li  11. Marital Status  1 Never Married 2 Marned	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	? No	21911 Was Decedent of His If Yes, specify Cubar		ocify Yes or No- Rican, etc.)	UNITED STA  14. Race - Americ Black, White, Specify: TAIL	ean Indian, etc.
led within 72 hours a ygiene. her than "natural", o nt. I'ra Medical Eran Completed by		3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	tion	ng 16	6b. Kind of Business/Inc	dustry
2 should be filed within and Mental Hygiene. Is marked other than aumatic event. It a Ma		12 17. Father's Name (First, Middle, Las			UCK DRIVE	18. Mother's Name	(First, Middle, Ma	GENERAL HA	AULING
12 should hand Men 7 Is marke traumatic		ROBERT PERRY MOX	(Type, Print)			nd Number or Rura		City or Town, State, Zip	
permit. Pages 1 and. Department of Health Importent: If item 27 any injury or other tr	-	ROBERT P. MOORE,  20a. Method of Disposition  1 \( \text{A} \) Burial 2 \( \text{Cremation} \) 3 \( \text{C} \)  1 \( \text{Donation} \) 5 \( \text{Other} \) (Spec	☐Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	MARCH	20 20	IARYLAND 21 ic. Location - City or To	wn, State
permit. Pa Departmer Important: any injury once.	Ī	21. Signature of Funeral Service Lice		H	K CEMETERS  2. Name and Address  ICKS HOME  1.2. W. SCHOOL	s of Facility FOR FUNEF	RALS, P.A	CALVERT, MA A. ON, MARYLA	
Physician /Medical Examiner		23a. Pert1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Methampho a	d the death. Do not en ine. etamine USe	ter the mode of dying	, such as cardiac o	r respiratory arrest	1,	Approximate Interval Between Onset and Death
death certificate be executed be attending physician and nd for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):				11	
death cer e attendin id for use iclan/N		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
w requires that the been signed by the should be detachered.		en II. Other significant conditions Cardionegaly with bi Focal moderate corons	contributing to death oventricular fary atherosc	out not resulting in the u lypert rophy, ri Lerosis	nderlying cause give <b>SIDE 1</b>	Liation and		cco use contribute to th	e cause of death? ably 4 □Unknow
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5 5 8 1		25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death	Hospital: 1 Inpati		nt 3 DOA Other	26. Place of Death  4 Nursing Homat  2		e 6 Other (Specify	)
Ital or Attending P Is after death. al Diractor: After t ied in by the funera Certification:		1 Natural 5 Pending investigation 3 Suicide 6 Could not to determined	on 2/2//U4tou	ind found4:  Injury found4:  jury - At home, farm, str  tc. (Specify)	35at 1□Y	es 2X No UI	Nknown  8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
To the Hospital or Attending Phymin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification: T		Check only 2 X Medical Exa	hysician: To the best minar: On the basis of	of my knowledge, deat of examination and/or in	er cab	date and place, a	695@195 NB,	Baltimore Co.	atod
within 2 To the complet		29b. Signature and title of certifier	Greense	eng MD	29c. License O.C.	number		Date signed (Month, L	
State	†	30. Name and address of personwho TOSHU Z GV CC 1 31. Date filed (Month, Day, Year)		). 111 Pen	n Street.	Baltimon	e. Maryla	and 21201	

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 amend 27 Per DR. g829 3/4/04 KB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MAVI Orris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HOSPITA!
7. Age (In yrs. last birthday)
Vrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) arbor If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months NO/M 2□ F Director 04 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!, or items 23e or 28e-f show any highry or other treumatic event, I'm Medical Evant er mat be notified at once. 10a. State 10b. County 10c., City, Town or Location-10d. Inside City Limits 1 ☐ Yes 2 No Funeral Directo Mrunch urnia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 893 1061 inited nes 12. Was Decedent Ever in U,S. Armed Forces? Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify If Yes, Give Year or Dates: Specify. á 3 Widowed 4 Divorced black. Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Intach I Ntant Intant Intant 17. Father's Name (First, Middle, Last) unk 18, Mother's Name (First, Middle, Maiden Surname) enn, Jun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital 3001 S. Hanover Street Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of horal Mice Licensee de State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Enter the disease, or complications, or heart failure. List only one caus Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? this certificate hes been signed by rail director, page 2 should be detect 3 Probably 4 Unknown 1 Tyes 2 <u>۾</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one, examiner? Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) CertIfication: 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred 5 Pending investigation 1 X Natural injury 1 Tyes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ard

32. Registrar's Signature

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3	ale of Maryland	Department	OI HEAILII AIIU	i ivientai mygiene	-	U	( )

				For State Registrar	State of Ma	rytant		tificate o				Reg. N		07059	
_		Physicia		Decedent's Name (First, Middle, La     Äura Johr		rker	t				2. Date of De Month Februa	0	Day Year 12 2004	3. Time of Death 12:35 AM	
	>	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town	n, or Loca			-	c. County of Death		
	*			Wicomico Nursi					lsibu			Wicomcio			
	L	Funeral Director		444-20-0441	6ex 7. Age 1□M 2 <b>x</b> F 9]		ast birthday) Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. urs Min.	8. Date of Bi (Month, D August	rth ay, Yea 10	9. Birthpo Coun ,1912 Mi	lace (State or Foreign try) SSOURI	
		/land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10	0d. Inside City Limits	
		e Man	ctor	Maryland Wicom:	lco	Sa	lisbur						1 X Yes 2 □ No		
		with th	Director	10e. Street and Number  900 Booth St.				10f. Zip Cod	801				Citizen of What Coun	try?	
+		death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13. V	Vas Decedent		c Origin? (Spe	cify Yes or N		14. Race - America Black, White,		
Marker	036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In Inportant: If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow any rojurry or other treumatic event, the Medical Evan has must be notified at the example.	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 N If Yes, Give Year or Dates:	0		l□Yes 2 <b>X</b>			,		Specify: White		
757	Maryland 21215-0036	n 72 ho "natur	ieted	15. Decedent's E (Specify only highest gr	ade completed)		16a. Deced (Give	lent's Usual Oc kind of work do OO NOT use re	cupation ne during tired)	most of worki	ng	16b.	Kind of Business/Inc	lustry	
M	212	d withingiane.	omo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Teac					Pu	blic Educ	ation	
2	and	be file ntal Hy ad oth	Be	17. Father's Name (First, Middle, Las.  Garland S. Johns						lother's Name aisie	(First, Middle Hahn	e, Maide	en Sumame)		
Jura	aryk	should nd Mei marka	2	19a. Informant's Name/Relationship			19b. Mailin	g Address (Str				ber, City	or Town, State, Zip	Code)	
F	, Ma	and 2 ealth a m 27 is		Marlene A. Quinn,	/step-daugh					7			nd, DE 1.9		
	nore	ages 1 nt of H t: If Itan / or oth		20a. Method of Disposition  1 ♣ Burial 2 ☐ Cremation 3 [		1		sition (Name of natory or other n Cemet		2/19/	ate /O/		Location - City or To		
	Baltimore,	mit. Partme partme pertani y njury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		GLE						-		ssociation	
	8	88 = 3			mpon	CFS	P	501 Snc	W Hi	ll kd.,	Salis	sbur	y, MD 218	04 Approximate	
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		Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a			71101	0	1	10000				
		exammer	-e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequ	uence of):								
		cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
	60,	icate be executed physician and s the burial-transit	a Ex	resulting in death) Last	Due to (or as a	a consequ	uence of):								
		_ "	edicai		d										
	Вох	eath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal	death 3	Ectopic pregna Other (specify					23d. Date of delive Month	ny Day Year	
	P.O.	that the deed by the delached	hysi	1  Yes 2 No 9  Unknown	9□ Unknown						_				
	Division of Vital Records, F	To the Hospitel or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	ρ	Part II. Other significant conditions	contributing to death bu	ıt not resi	ulting in the u	nderlying cause	given in f	Part I.			o use contribute to th	e cause of death? ably 4 ∐Unknown	
	eco	law re nas bee s 2 sho	Completed								24a. Was	psy	24b. Were autop	osy findings available npletion of cause of	
	al B	n: The licate har, page									1 ☐ Yes			2□ No	
	Ş	s certil	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	nt 2 🗆	ER/Outpatien	t 3 DOA	Other:	Place of Death			6 □Other (Specify	()	
	n of	ding Physician:  A. After this certific funeral director,		27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date of Injur (Month, Day	у	28b. Time of Injury		njury at Work?		28d. Describe			,	
	isio	ttendideath.	icatio	2 Accident investigation 3 Suicide 6 Could not	De Diago of Inju	irv - At ho	me larm str		1 ☐ Yes		28f Location	(Street	and Number or Rura	I Route Number.	
	Οį	el or A s after of Direct	Sertif	4 Homicide determined	building, etc	(Specify	(1)	ooi, idolosy, on			City or To				
		To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Certification;		hysician: To the best of miner: On the basis of	examina									
_		o the	Med	29b. Signature and title of certifier	and manner sta	190.		29c. Lic	ense num	ber		29d. [	Date signed (Month, I	Day, Year)	
		->-0		my my				D.S	560	6		FE	BRUARY	12 2009	
	1	(ono		30. Name and address of person who									0	,	
		- 111		Mohan Bhat M.D.	614 East			rive Sa	lisbu	iry 218	104				
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			State of Maryland / Dep	partment of Health and ertificate of Death		ne No 2004	07060	
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	/Medic Examir	al	ELVIRA MOLL  4a. Facility Name (If not institution, give street and number)  5636 Clydesdale Drive	4b. City, Town, or Location of Deat Salisbury	FEBRUARY	13,2004 4c. County of Death Wicomic	6:35 a M	
	Funeral Director		5. Social Security Number  489-05-1513  6. Sex   7. Age (In yrs. last birthda)   7			9. Birthp Cour	lace (State or Foreign stry)	
	ahow od at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I				0d. Inside City Limits 1 ☐ Yes 2√ No	
	with the A la or 28a-i Le notifi	Direct	Maryland Wicomico Salisb  10e. Street and Number  5636 Clydesdale Drive	10f. Zip Code 21801	10 <b>g</b> .	Citizen of What Cour	try?	
336	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f ahow ont, the Madical Examinar must be inclified at	by Funeral Director		Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,		
Maryland 21215-0036		Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1·4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) Estate Agent	rking	ental Prop	dustry	
land 2	be file ital Hyg d othe	To Be C	17. Father's Name (First, Middle, Last) John LaMacchia		me (First, Middle, Maid			
	nd 2 shulth and 27 is m			ing Address (Street and Number or Ri 36 Clydesdale Dr.				
Baltimore,	Pages 1 and nent of Healt ant: If item 2 ary or other		A Deserting E DOther (Conside)	on barracks		Location - City or To		
Balti	permit. Pages Department of Important: If i any injury or once.		2 signature of Funeral Service Licensee	Name and Address of Facility Holloway Funeral 501 Snow Hill Rd.	Home Profes	ssional As	sociation	
8760,	whysician and hysician and hysician and the burial-transit	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		c or respiratory arrest,		Approximate Interval Between Onset and Death	
O. Box 687	death certific e attending p od for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year	
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of Vital Record	The law ate has b page 2 s	Completed	Atrial Fibrillation advanced age		24a. Was an autopsy performed 1 Yes 2 🔽	prior to con death?	osy findings available inpletion of cause of	
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatii	Other	ath (Check only one)  Home 5 Mesidence	6 □Othor (Specific		
	fing After fune		27. Manner of Death  127. Manner of Death  128a. Date of Injury  128b. Time  129. Month, Day Year)  129. Injury  129. Television  120. Televi		28d. Describe how in		)	
Division	ital or Attencrs after death rs after death ral Diractor: led in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural late)	Route Number,	
	To the Hospital or within 24 hours after Youhe Funeral Direction Completely filled in E	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  2 Medicel Exeminer: On the basis of examination and/or is  and manner stated.	th occurred at the time, date and place expressigation, in my opinion, death occu-	urred at the time, date	and place, and due to	the cause(s)	
	11) A		29b. Signature) and title of certifier	D5542	7 Feb	Date signed (Month, L)  - 13, 2	004	
- (	M		30. Name and address of person who completed cause of death (Item 23a) (Type D-Christan Bounds 10	6 Miltond St.	Salisbury	Md 218	504	
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24-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		ff Und	er 1 Year	If Under 24 Hrs	s. 8.	Date of Birth	9. Bir	Charles  9. Birthplace (State or Foreign Country)		
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Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow tra Madical Exertitivat raist be retified at	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1∐ Yes	2 <b>X</b> No	Specify:			Specify: Wh	ite		
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N	filed w Hygier other th		10 17. Father's Name (First, Middle, Last)		Wan	tres	S	18. Mother's Na	ame (Fi	rst Middle M	<u>restauran</u>	t		
auc	d be f	o Be	Thomas Wamble					Lola			alder Surrame,			
2	should Ind Men	ဥ	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Maili	ng Addre	ss (Street a				City or Town, State,	Zip Code)		
	nd 2		Delores A. Goldsmi	ith-daughter	4755	Duff	ield	Road W	hite	Plain	s MD 206	95		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or items 23a or 28a-f ehow any njury or other traumatic event, It a Madical Examinus Trans Les natified at ODGs.	-	20a. Method of Disposition	20b. I	Place of Dispersion	osition (N	ame of		Date		Oc. Location - City or			
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a	permit. Departm Imports eny inju		21. Signature of Funeral Service Lisense		3 H <sup>2</sup>	2. Name	and Addres	al Facility al Home	1.00000	.00+ 011	CI CCIII CIII 9	100		
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Вох	h cert endin use	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Testania	pregnancy				23d. Date of de	livery		
ω.	deat ne att	sicie	in the past 12 months? 1 ☐ Yes 2 € No	4 Pregnant at time of o		Other (					Month	Day	Year	
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Division of Vital Records,	Attending Physician: Ir death. ector: After this certifica by the funeral director. p	Be	25. Was case referred to medical examiner?	ospital:	7		Othe	26. Place of De				-		
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Ö	s after s after si Direct	Cert	4   Homicide	building, etc. (Speci	(Y)					City or Town,	State)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 17 Certifying Phys	ician: To the best of my kn	owledge, dea	th occurre	d at the tim	e, date and place	ce, and	due to the car	use(s) and manner a	s stated.	a(e)	
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	Voit To COL	Σ	29b. Signature and title of dertifler			2	9c. License			29	d. Date signed (Mon	th, Day, Year)	)	
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à.	品点		30. Name and address of person who co				#100	- اداما	ν£	MD 200	:02			
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ysician		<ol> <li>Decedent's Name (First, Middle, L</li> </ol>	ast)							2. Date of De Month	ath Day	Year	3. Time of D	eath
ledical	Ŀ	RICHARD E. NORRIS								02	03	2004	1710	M
aminer		la. Facility Name (If not institution, g		mber)				Location of				ounty of Death		
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4	-1	10a. Slate 10b. County		10c. C	ity, Town or L	ocation					_	1	0d. Inside City	Limits
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a la		31843 BEAUMONT C	IRCLE			218	49					USA		
Funeral		11. Marital Status	12. Was Deci	edent Ever in U	U.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	. Race - Americ Black, White,		
by Fu		1 Never Married 2 Married	1 X Yes If Yes, Gir	ve		1 ☐ Yes 2		Specify:		, , , , , ,	1	pecify: WHI		
D D		3 ☐ Widowed 4 ♣ Divorced	Year or D	ates:										
	_	15. Decedent's (Specify only highest g			(Give	dent's Usua kind of wor DO NOT us	k done c	turina mosi	t of work	ing	16b. Kind	of Business/In-	dustry	
Ē		Elementary/Secondary (0-12)	College (1	1-4or 5+)		ECHNI					NATT	ONAL SE	CHRITY	
To Be Comp		17. Father's Name (First, Middle, Las	<u> </u>						r's Nami	First, Middle			OOKLII	
0		SAMUEL ELMER NOR	RTS. JR.					RIITH	EVE	LYN HAN	SON	,		
-	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a					Town, State, Zip	Code)	
8   -		JOAN L. BAYSINGE	R – DAUG	HTER							-	LAND 21		
	12	20a. Method of Disposition			Place of Dispo	sition (Nam	e of	- 1		Date		ition - City or To		
		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			-	-			)2 <b>–</b> 0	9-2004	HFRRO	N, MARY	TAND	
ej ej	$\vdash$	21. Signature of Funeral Service Lie		lor.		2. Name and						HOME,		
once		11 plessa la	1 Her	un	1/				DO			,MARYLA		14
dical Examiner		23a. P. 1. Enter the disease, or cashock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	(or as a consector as	quence of):	240	or dynn	y, such as	cardiac	л төэрлахогу аг	1951,		Approximate Interval Betwee Onset and De	
Physician/Medical		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		oirth 2 ☐ Fet nant all time of	al death 3	□Ectopic pre □ Other (spe					230	d. Date of delive	ory Day Yea	ar
þ	, '	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the u	nderlying ca	use give	n in Part I.			obacco use es 2 🗆	contribute to the		
Completed	1									24a. Was		24b. Were auto		
Comp											med?	death?	npletion of cau	se of
0		25. Was case referred to medical						26 Place	of Death	1 Yes	2 (I) (No	1 🗆 Yes	2 □ No	
ToB		examiner? 1 🖫 res 2 🗋 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DO	Othe			The state of the state of		]Other (Specify	()	
		27. Manner of Death  1  Natural 5 Pending 2 Accident investigati	28a. Dale (Mon	of Injury th, Day Year)	28b. Time o Injury		c. Injury Work	at		28d. Describe h			7	
Certification:		3 Surcide 6 Could not determine	4 289. Place	of Injury - At h ng, etc. (Speci	nome, farm, str ify)	reet, factory,	office			28f. Location (5 City or Tov		Vumber or Rura	l Route Numbe	r.
Medical Certificat		29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ext	iminer: On the bi	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred a vestigation,	t the tim	e, date and inion, deat	d place, a	and due to the ded at the time,	cause(s) ar date and pl	nd manner as st ace, and due to	ated. the cause(s)	
Σ		29b. Signature and title of certified				29c.	License	number			29d. Date s	igned (Month, I	Day, Year)	
		lunden)					175	040	1)		2/51	04		
		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)	100	11 < 4	-	Sal	ich	NO	21201	
		CINIS OF SICE			100		-440	11 7	,		1000	4		

Spake

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 200 4 620AN Frances Odel Privett /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner S If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 12, 1927 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F June 230-30-4586 Director Virginia 76 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at MD 1 Yes 2 XNo Funeral Director Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 406 Aldino-Stepney Road 21001 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by 3 ☑ Widowed 4 □ Divorced Yeer or Dates: White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker In home 6 other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Haalth and Mentai I tem 27 la marked or Luther James Goble Dora Goble 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Privett (Son) 406 Aldino-Stepney Rd., Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: if Iter any Injury or off 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Harford Memorial Gardens 3/6/04 Aberdeen, Maryland <sup>22. Name and Address of Facility</sup> Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licenses 21001-3399 333 South Parke St., Aberdeen, MD esno. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requiras that tha death certificata be executed the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien Division of Vital Records, P.O. Box 6876 NOC Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 2 No 3 Probably 4 Unknown 1 Yes ģ icata has been sig r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? 20 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No certificata or Attending Physician: 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO Certification: To 1 ☐ Yes 1 🗆 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Dey Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending deeth. М 1 ☐ Yes 2 ☐ No investigation 2 Accident **Director:** within 24 hours after dee To the Funeral Director completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) (Item 23e) (Type, Print) 30. Name end address of person who

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours a

To the Funeral I

completely filled

Medical Certification: To Be Completed by Physician/Medical Examiner

andox, or ribalt failure. Elst only	one cause on each line.			Onset and Death
Immediate Cause (Final disease or condition resulting in death)	· acute reval	failure		1 week
,	Due to (or as a consequen	ce of):		
	a dehidratu	~		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es e consequen	ce of):		
that influed events resulting in death) Last	Due to (or es e consequen	ce of):		
Part II. Other significant conditions of	contributing to death but not resulting in the under	lying cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown
cerebovascula	r accident		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
winery t	not infection		1 Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Dea	th (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient	3□ DOA Other: Nursing He	ome 5□ Residenca 6□Oth	er (Specify)
27. Manner of Deeth  Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined		factory, office	281. Location (Street and Numb City or Town, State)	er or Rural Route Number,
	hysician: To the best of my knowledge, death oc miner: On the besis of examination end/or invest end manner stated.			
29b. Signature end title of cartifier	/ /	29c. License number	29d. Date signe	d (Month, Day, Yeer)
1 Challen		D30823	2/9/	14

1346 S. Division St. Suite, Salisbury, Md. 21804

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2004

07064

1:20 PM

Birthplece (Stete or Foreign Country)

Maryland

10d. Inside City Limits

1 X Yes 2 No

7.2004

14. Raca - American Indian,

white

Approximate

Black, White, etc

Registrar **DHMH 16 Rev 6/95** 

State

Charles

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

Silvia T1 2004

		1 - For State Registrar	State of Marylan		artment <i>rtificate</i>			ınd Me		iene,	200	4	07065
		1. Decedent's Name (First, Middle, Last)						2	Date of Deat	h Day	Ye	ar	3. Time of Death
Physic /Medi		RICHARD	MATTHEW	P	LUDE			F	EBRUA				1914 M
Exami		4a. Fecility Name (If not institution, give :	street and number)	· / · -	4b. City, To	own, or	Location o	f Death		/4c. C	ounty of C	_	*
		PONINSULA REGIONA	1 Medical 1	INSU		54	14136	414				com	100
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day, PRIL 2	Year)	9.	Count	ece (State or Foreign
Director		1/1-26-5281	70	Yrs.				A	PRIL 2	6,19	33   P	ENNS	SYLVANIA
pur 🛊		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Lo	ocation							10	d. Inside City Limits
aryla eho	ž												1 ☐ Yes 2 📉 No
he M	Director	DELAWARE SUSSEX  10e, Street and Number		SELBYV	10f. Zip C	Code			1	On Citize	en of Wha	t Count	n/2
with t	D.	3 TAFT AVENUE, C	ADE LITMDCOD		,	9975				og. Omz	USA	Count	,,,
death with the Maryland me 23a or 28a-f show findst be notified at	Funeral		12. Was Decedent Ever in U	IS 13				nin? (Speci	fy Yes or No-	14	4. Race - A	America	n Indian
ltem	n.	11. Marital Status  1 X Never Married 2  Married	Armed Forces?		If Yes, specif	y Cubar	n, Mexican	, Puerto Ri	can, etc.)		Black, V	Vhite, e	itc.
I', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1953	-55	1 ☐ Yes 2	X No	Specify:			5	Specify:	WH	ITE
be filed within 72 hours after death with the Marylan stal Hygiene.  d other than "natural", or Iteme 23a or 28a-f show of other than "natural", or Iteme 23a or 28a-f show event, the Medical Exempter must be multified at		15. Decedent's Edu	cation	16a. Dece	dent's Usual	Occupa	tion			16b. Kin	d of Busine	ess/Ind	ustry
n n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) Coltege (1-4or 5+)	(Give	kind of work DO NOT use	done d retired)	uring most	t of working	'				
d within jiene.	E	12	College (1-401 0+)		SAFE	ry d	IRECT	ГOR		Γ	RUCK	ING	
e filed Il Hygie other vent, Il	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (i	First, Middle, I	Maiden S	Sumame)		
should be nd Mental marked c	ToE	HENRY	D. H	LUDE			MA	ARIE		F.	K	ITWI	ELL
		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (	Street a	nd Numbe	r or Rural F	Route Number	. City or	Town, Sta	te, Zip	Code)
and 2 salth a n 27 is		DOTTIE BRESSETT/NI	ECE	57 FC	X MEAI	DOW	DRIVE	E, SIC	CKLERVI	LLE,	N.J	. 08	3081
es 1 av of Hea fitem r otha		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F		Place of Disponentery, crea	osition (Name matory or oth	e of ner place	9)	Dat	10	20c. Loc	ation - City	or Tov	vn, State
		1 □ Bunal 2 ▲ Cremation 3 □ P	CRI	MATORY	OF DI	ELMA	RVA 2	2/10/0	04	DELN	IAR,	DEL	AWARE
permit. Pag Department Important: I any injury o		21. Signature of Furierat Service Licens	6 HA	2:	2. Name and	Addres	s of Facility	у					
99 1 2 8	7	when the	my WIT	HA	STINGS	S FU	NERAI	L HOME	E, SELE	YVII	LE,	DE.	19975
Physician /Medical Examiner		23a. Part 1. Enter the disease or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause of each line.  PREUM  Due to (or as a consecution)	ONLA	ter the mode	of dying	g, such as	cardiac or i	respiratory arr	est,			Approximate Interval Between Onset and Death
acuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a consect.  Due to for as a consect.										
ate be exemply sician a the burial-	ca		d										
rtifica ng ph as th	Jed	iF FEMALE:											
atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3	□Ectopic pred □ Other (spec					23	3d. Date of Month		ry Day Year
that the ed by th detache	Phy	9 Unknown		nulting is the	and and the control of		e in Oc at		220 Bid +-	haoss :::	0.000	to to th	e cause of death?
law requires that the de as been signed by the. 2 should be detached	þ	Part II. Other significant conditions co	nthouting to death but not res	suiting in the t		use give	in in Part I.			es 2		] Proba	
law requires t as been signe	Completed	<u> </u>							24a. Was a		24b. Wer	autop	sy findings available
0 = 0	E								perform	ned? 2 No	deat	h? .	2₽No
iician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (	Check only on				
S 0 1	To B	examiner?	Hospital: 11 Inpatient 2	] ER/Outpatie	nt 3 DOA	Othe	or: 4 □ Nu	rsing Home	5 ☐ Reside	ence 6	Other (	Specify	)
		27. Manner of Beath	28a. Date of Injury (Month, Day Year)	28b. Time of	if 28	c. Injury Work	at	28	d. Describe h	ow injury	occurred		
Attending I rr death. ector: After by the funer	atlo	1 Natural 5 Pending Investigation	(Month, Day 700)	injury	М		/es 2 □ l	No					
P afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory,	office		28	f. Location (Si City or Town	treet and n, State)	Number o	r Rural	Route Number,
To the Hospital within 24 hours of To the Funeral completely filled	edical (	29a. Certifier T Certifying Phy Checklonk 2 Medical Exami	sician: To the best of my known iner: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred a vestigation, i	t the tim	e, date and pinion, deal	d place, an th occurred	d due to the c	ause(s) a ate and p	and manne place, and	r as sta due to	ited. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date	signed (M	fonth, [	Jay, Year)
F > ₩ 0		News -			0	557	200			FIER	RUA	Red	9 2004
A -		30. Name and address of person who co	ompleted cause of death (tie	m 23a) (Tvpe						,	, ~~ (VII	-	4
Da		Modani	BHAT - 616	-BE	ASTE	au	SHO.	P85	PRIVE	<	JACI.	SSC.	RY NO
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1		.,,	- No.					7.8.0
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DHMH 17 Rev 1/2001

PLUDE 171-26-5281

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 4 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Physician 1.58AN OOVER 00 DL /Medical 4b. City, Town, or Location of Death 4c. County of Dea 4a Facility Name (If not institution, give street and number) Examiner VA MEDICAL ALI IMORE CENIER ALIMORE If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours TXOXM 2□ F 242- 38-7472 Yrs. June 6,1929 NORTH, CAROLINA Director Usual Residence of Decedent should be filed within 72 hours after death with the Meryland Mantel Hygiane. marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X ☐ No Funeral Director Maryland | Cecil. E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21921 386 Tony's Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1X Yes 2 No 1952— If Yes, Give Year or Dates: 1954 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Be Completed by 3 Widowed 4 Divorced White 1954 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Pumper 8 permit. Pages 1 end 2 should be file Department of Health end Mantel Hyg Important: If Item 27 is marked other any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Blanche Thomas** Will Potter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spouse Josephine Potter 386 Tony's Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Removal from State 4 Donation 5 Other (Specify) Church of Christ 21,2004 Elkton, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Ith Rapid Venticular Research Examiner Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the deeth certificeta be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 10 ant alu 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 2 🗆 No 1 Tes 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ►☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only 29c. License number 29d. Date signed (Month; Day, Year) 29b. Signature and title of certifier 76560 Martin La lusta 10+1 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) GREENE ST. BALTIMONE MIL 21201

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB 19 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 07067 For WiCHD, dq State of Maryland / Separation of Floating State Registrar Amend#23b,c,02-17-04,PerPHY Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARY E. RUSSO 02 11 2004 6:45 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTOWN NURSING & REHAB CENTER CHESTERTOWN OUEEN ANNE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕅 F 02-06-1915 89 ROSETO, PA. Director 180-09-6507 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No MD WICOMICO SALISBURY Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "netural", or items 23a or 225 CANAL PARK DRIVE, UNIT #4 21804 USA death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2X☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify Specify: þ 3 □ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ire Me Elementary/Secondary (0-12) College (1-4or 5+) stal Hygiene. ad other than event, the M SEAMSTRESS GARMENT FACTORY 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be marked PETER CISTONE 2 CONSTANCE LIBERTO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, rtment of Health a rtant: If item 27 it riury or other tra-REBECCA RUF - DAUGHTER 225 CANAL PARK DRIVE, UNIT 4, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Important: I eny injury o once. RQSETO PRESB.CEMETERY 02-14-2004 4 ☐ Donation 5 ☐ Other (Specify) ROSETO, PENNSYLVANIA permit. Departr 21. Signature of Funeral Service Licens 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. cott 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 2/115 **Physician** NEINZ FUTILLE MULLIC resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE CHF if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed MYOCARDIAL INSUFFICIENCY attending physicien and for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) TYPS 2 NO P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 1NO or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2 1 | Yes 2 | N 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide after within 24 hours a To the Funerel I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29h Signature and title of certifier 29c. License number 2-11-04 10013824 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEYMOUR. M.D. 122 SPEER RD. SUTTES CHESTERTOWN MD. 21420 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks FEB 1 7 2004 Registrar

		1 = For State Registrar	State of Marylar	id / Depa <i>Cei</i>	artme <i>tifica</i>	nt of Health a te of Death		R	eg. No.	004		
Physici	an	Decedent's Name (First, Middle, Last	(n)					. Date of Deat Month	Day	Year	3. Time of Death	
/Medic	cal	DTEPHENLS	HELLEY		4h Cih	, Town, or Location o		EBRUARY	Ac Coun	2004 ty of Death	4.47 P	
Examin	er	4a. Facility Name (If not institution, give	1.1		5			,	40. 000			
Francis		5. Social Security Number 6. S	MARYCAND ex 7. Age (In yrs.	last birthday)	If Und	ALTIMOR er 1 Year   If Under 2	24 Hrs.   p	. Date of Birth	Maria	9. Birthp	lace (State or Foreitry)	ign
Funeral Director			MM 2□F 35	Yrs.	Months	Days Hours	Min.	ept I	8,196	8 Was	sh.D.C.	
		Usual Residence of Decedent										
ıryları bhow	_	10a. State 10b. County		ty, Town or Lo						1	0d. Inside City Limi 1 ☐ Yes 2 1 1 1	
Ba-f e	cto	MD Baltin	nore Fr	eelan					0- 00	-		
vith th	Die	10e. Street and Number 20924 Mt. Zior	Poad			ip Code 21053		'	USA	of What Coun	ntry r	
death with the Maryland ime 23a or 28a-f ehow Ir must be inclibed at	a		12. Was Decedent Ever in U	S 13		edent of Hispanic Orig	gin? (Speci	fv Yes or No-		ace - Americ	en Indian.	
or Its	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 COvorced	Armed Forces?  1 Yes 2 XNo If Yes, Give Year or Dates:		If Yes, sp	ecify Cuban, Mexican 2 No Specify:	, Puerto Ri	can, etc.)		lack, White,		
Pours Phours attural; o	ed	15. Decedent's Ed	ducation	16a. Dece	dent's Us	ual Occupation			16b. Kind of	Business/Inc	dustry	
nin 72	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of v DO NOT	rork done during most use retired)	t of working	7	Law E	Enfor	cement	
d with giene.	E	12	00110gb (1 401 01)	Comm	erc	lal Vehic	cle 1	nspec	tor			
d be file antal Hyge ced othe	Be C	17. Father's Name (First, Middle, Last)						First, Middle,				
aryiand should be filed and Mental Hyg	2	Harold Euger	ne Snields					Sene S				
2 sho and and le mu		19a. Informant's Name/Relationship (	** *		-	ss (Street and Numbe						
e, IV 1 and 1 and Health 1 mm 27 other tr		Linda G. Shelle		Place of Dispo		Zion F	Da	to T		n - City or To		_
Datitimore, in permit. Pages 1 and Department of Healin Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State YO	rktown Serv	natory of	remation	Feb. 200	28,	York	•		
Dearmit. Depart Import eny inj		21. Signature of Funeral Service Light	tensteri	J 2	. J 4 S	and Address of Facility Hartens econd St	steir ., Ne	w Fre	edom.	Inc.	i7349	
		23a. Part1. Enter the disease, or com	plications that caused the dea	th. Do not ent	ter the m	ode of dying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Sensis								Onset and Death	
/Medical		resulting in death)	Due to (or as a conse	quence of):	1	· ,						
Examiner		Sequentially list conditions,	b. Soft t	issue	in	ection						
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<b>60,</b> be executed ician and burial-transi	Examine	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):	eno	VISLAR						_
8/60, rate be executed hysician and the burial-transit				V						- 1		
.U. BOX <b>B8/BU</b> , the death certificate be ex y the attending physician iched for use as the burial	edical		d									_
BOX (ath certif	₹ N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		·				23d. I	Date of delive	ery	
death death death	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		JEctopic ☐ Other (	pregnancy specify)			1	Month	Day Year	
	hys	9 Unknown	9□ Unknown									
Hecords, P.O. The law requires that the de ate has been signed by the page 2 should be detached	by P	Part II. Other significant conditions		sulting in the u	inderlying	cause given in Part I.	•				ne cause of death?	
ecords, law requires t as been signe	ed	hespiratory +	AILURE				_	1 🗆 Y	es 2 No	3 Prob	pably 4 Dunkno	WIT.
Q & % S	pie							24a. Was a autop		b. Were auto	psy findings availal	ble of
The The page	Completed							perfor	med? 2⊠ No	death? 1 ☐ Yes		
Of VITAL MC Physician: The l this certificate ha	Be C	25. Was case referred to medical examiner?					of Death_	Check only or	18)			
Of V Physic r this ce	To I	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3			e 5 🗆 Resid			y)	
ng Pl		27. Manner of Death  ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o		28c. Injury at Work?		3d. Describe h	ow injury occ	curred		
SIO eath. or: A	cati	2 Accident investigatio		1	М	1 Yes 2		M 1 (C			10- to 11 mbos	
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide determined			reet, fact	ory, office	20	City or Tow	n, State)	mider or Aura	al Route Number,	
Hospi 24 hour Funer itely fill	Medical		nysician: To the best of my kn miner: On the basis of examin and manner stated.									
o the	Me	29b. Signature and title of certifier			:	9c. License number		2	29d. Date sig	ned (Month,	Day, Year)	
<b>⊢ s ⊢</b> ō		1 mil	ans.			00059	720	3 F	FARLA	20 20	7 1004	
. (		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)		/ )		PEUAI	Ly o	,	
10		29 S. Greene S	Freet BAI	TIMO	RE.	MD 212	01	; Mu	N1514	GOVA	1, 2004 L. M.D.	
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	A SECOND	A 61 2				7		
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Registrar

31. Date filed (Month, Day, Year)

FEB 17 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2001

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		•	Certificate of	Death	Reg.	No.	0/0/0
Physician	1. Decedent's Name (First, Middle, Last)		==/	:	2. Date of Deeth	Day Year	3. Time of Death
Physician /Medical	Mary F. Simmons				February	19, 2004	
Examiner	4e Fecility Name (If not institution, give:			4b. City, Town, or Loca	ation of Deeth	4c. County of Deatl	
Funeral	Sunbridge Care and 5. Social Security Number 6. Sec		ast birthdey) If Under 1 Yea		B. Date of Birth	Ceci 9. Birti	hplace (State or Foreign
Director	216-24-4133	M 2XF 78	Yrs. Months Days		Month, Dey, Ye anuary 2		West Virgini
irylanı show	10a. Stete 10b. County	10c. City	, Town or Location				10d. Inside City Limits
vith the Marylar t or 28s-f show be notified at Director	MD Cecil	No	rth East				1 ☐ Yes 2 🌠 No
with the Direct	10e. Street end Number		10f. Zip Code		10g.	Citizen of What Co	untry?
Siter death with the rest and the rest of the second secon	112 Red Toad Road	2. Was Decedent Ever in U,S	2190	1 Hispanic Origin? (Spec		USA 14. Race - Amer	rican Indian
D36	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	If Yes, specify Cul	ben, Mexican, Puerto R	ican, etc.)	Black, White	
21215-00 ed within 72 hou ygiene. her than "nature nt, the Medical E	15. Decedent's Educ (Specify only highest grede	etion	16a. Decedent's Usual Occu	petion a during most of working	16b.	. Kind of Business/I	Industry
Waryland 2121 d2 should be filed within h end Mental Hygiene. 7 ie marked other then ", traumatic event, the Mer To Be Compie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)			
Hygien Hygien int, the the	9 17. Fether's Neme (First, Middle, Last)		Laborer	18. Mother's Name (		Manufactu	ıring
d 2 should be file th end Mental Hy ? ie marked oth traumatic event To Be (						ion comanic)	
should nd Men marke umaric	Allen Martin  19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailing Address (Stree	Nellie Lu		ty or Town, State, Z	ip Code)
CENL	Susan McBreen/Soci	al Worker	170 E. Main	Street, Elk	ton, MD	21 921	
of Healt	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	20b. Pla	ace of Disposition (Name of metery, crematory or other pla	ace)		Location - City or T	Town, State
callimore, mit. Peges 1 er pertment of Hear pertment of Hear portant: if item 2 y injury or other 28.	4 □ Donation 5 □ Other (Specify)	E1k	ton Cemetery	02,	/24/04	Elkton,	MD
permit. Peges 1 Depertment of H important: if ite eny injury or ott price.	21. Signature of Funeral Service License	· K	22. Name and Addr Andrew G.	Gee		. Main St	
	23a. Part1. Enter the diseese, or complishock, or heart failure. List only on	cations that caused the death.	Funeral Ho	ing, such as cardiac or	ELKTOI respiratory arrest,	n, MD 219	Approximate
Physician						1	Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	Septie Sho	eh_				Conknown
	resulting in death)	Septice Sho Due to (or Urinary	as a consequence of):				Tenknown Tenknown
min insit	<b>a</b> b	Wrindry	Pract Infe	clien			unknown
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ifficate be executed gphysicien and as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequence of):				
الله الله الله	resulting in death) Last						
at the death control of the death control of the attendetect of the detect of the death o	Part II. Other significant conditions conf	ributing to death but not result	ting in the underlying cause g	iven in Part I	23h Did tohac	co use contribute	to the cause of death?
by the	Diabota	no00-1-	g and disposity and decide gi				obably 4 (Tunknown
es the igned be de	Diologenes V	roccius					
Attending Physician: The law requires that the death cer reseth.  ector: After this certificate has been signed by the attending that funerel director, paga 2 should be detached for use iffication: To Be Completed by Physician/N	Ceremovasi	Nellitus cular Acci	dent		24a. Was an eur performed?	? ar	Vere autopsy findings vailable prior to ompletion of cause f death?
Tha is ate happega					1 ☐ Yes	2 1 No 1	☐ Yes 2☐ No
ician: Thi	25. Wes case referred to medical exeminer?			26. Place of Death (			
Physic this or rel dire	1 Yes 2 No	· · · · · · · · · · · · · · · · · · ·	H/Outpetient 3 DOA	her: 4 Nursing Home	5 Residence	6 ☐Other (Special	ify)
dling I	1 ☑Naturel 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c. Injury Wo	ryat ork? ]Yes 2 □ No	d. Describe now in	jury occurred	
of Attending Physician: The law requires that the after deeth.  Director: After this certificate has been signed by the lin by the funeral director, pega 2 should be detache ertification: To Be Completed by Physe	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office		f. Location (Street: City or Town, Sta	and Number or Rur	ral Route Number,
itai or is aftr is Dir is Dir is Cer							
To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completaly filled in by the funeral director, Medical Certification: To Be (	29a. Certifier (Check only one) 1 Certifying Phyei 2 Medical Examin	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death occurred at the ti on end/or investigation, in my	me, date and place, and opinion, death occurred	d due to the cause at the time, date a	(s) and manner as a and place, and due to	stated. to the cause(s)
within Con	29b. Signeture end title of certifier	0	29c. Licen			Date signed (Month,	, Day, Year)
	) le	holer S	200	023322		2.21.04	
\	30. Name end eddress of person who con SSSACHDEV	npleted cause of deeth (Item 2	23e) (Type, Print)	023322 eh ton MD	21921		
State	31. Date filed (Month, Dey, Year)	32. Registrer's Signatu		15 411 7			
Registrar	FED 9 4 2004		A 100 a				

ORIGINAL

DHMH 16 Rev 6/95

	1 - For State Registrar		partment of Health and ertificate of Death	Reg. N	<u>. 2004 0707</u>
Physician /Medical Examiner	Decedent's Name (First, Middle, Late     Virginia E. Simple     4a. Fecility Name (If not institution, give	son	4b. City, Town, or Location of Dea	February 2	year 3. Time of Death 2 2004 3:13 PM
Funeral Director	Union Hospital  5. Social Security Number  218-38-3932  Usual Residence of Decedent	ex	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		
Ba-f show	10a. State 10b. County  MD Cecil	10c. City, Town or Elkton			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
s within 72 hours after death with the Maryland iten. I then "natural" or Itams 23s or 28s-f show the Medical Evaninar must be notified at ompleted by Funeral Director	10e. Street and Number  88 Dogwood Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. 1 Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	10f. Zip Code  21 921  3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue)  1 □ Yes 2√2 No Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: White
a filed within 72 hours at Hygiene. other then "netural", vent, the Medical Example 18 Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Gi life College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wi by DO NOT use retired)  SEWIFE		Kind of Business/Industry  Domestic
be fill H od oth even	17. Father's Name (First, Middle, Last)	Typa, Print) 19b. Ma	18. Mother's Na  Lottie  Liling Address (Street and Number or F		
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is market any injury or other traumatic once.	Mary J. Carter/S:  20a. Method of Disposition  1  Burial 2 Cremation 3 Carter (Specific Control of	20b. Place of Dis   Cemetery, or   Removal from State	position (Name of rematory or other place)  Cemetery  O2/	Date 20c.	921 Location - City or Town, State kton, MD
Physician	disease or condition	1// //	22. Name and Address of Facility Andrew G. Gee Funeral Home, FA enter the mode of dying, such as cardia	259 F1kt- ac or respiratory arrest,	E. Main Street on, MD 21921 Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit the burial-transit and the burial-transit than the burial transit and the burial transit	resulting in death)  Socientially st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):  C. CHYDIC OB:  Due to (or as a consequence of):	STEUCTIVE PULM	1210 mmu DISE	1 W == 10 YRS
death certific e attending p ed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		3 ⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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The law ate has b page 2 si				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	
To the Hospital or Attending Physicien: The within 24 hours atter death.  To the Funsel Director. After this certificate completely filled in by the funeral director, page and the funeral director, page and the funeral director.	examiner? 1 Yes 2 No	28e. Place of Injury - At home, farm.	ient 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No		ury occurred  and Number or Rural Route Number,
To the Hospital or Attendia within 24 hours after death. To the Funerel Director: A completely filled in by the tu	4 Homicide  29a. Certifier (Check only 2 Medicel Exar	building, etc. (Specify)  ysician: To the best of my knowledge, de niner: On the basis of examination and/or	eath occurred at the time, date and place	ce, and due to the cause curred at the time, date a	(s) and manner as stated.
To the H within 24 To the F complete	29b. Signature and title of certifier  Midwl M.	and manner stated.	29c. License number  D 0 0 5 6 6	290.0	late signed (Month, Dey, Year)
5 State	30. Name and address of person who MISAEL M. M 31. Date filed (Month, Day, Year)		110 W. 9th St. #32	a, WILMINGT	70N, DE 19801

			For State Ragistrar	State of Maryla		artment of H rtificate of L		_		04	07072
	Physici		1. Decedent's Name (First, Middle, Last)	ES L. SIMMON	IS. JR			2. Date of Death Month Felikunn	n Day	Yeer	3. Time of Death
	/Medio		4a. Fecility Name (If not institution, give to 154 WEST DEEN ST	street and number)			Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Sex		rs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 24	Year)		ace (State or Foreign try) ISVIVania
	D	ō	Usual Residence of Decedent  10a. State 10b. County	rford 10c.	City, Town or Lo	cation Aberdeen			, ,,,,	10d. Inside City Limits 1 □ Yes 2 🏋 No	
	with the N or 28e-1 be rollf	Direc	10e. Street and Number 154 West Deen St			10f. Zip Code	1001	10	g. Citizen of W	hat Count	try?
36	72 hours after death with the Maryland naturel; or Items 23e or 28e-f ehow itsal Examinet must be notified at	by Funeral		12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No 1fYes, Give Year or Dates: 194.		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	spanic Origin? (Sr	pecify Yes or No- Rican, etc.)	14. Race Black	- America c, White, e	etc.
Maryland 21215-0036	1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then " ther treumetic event, I're Me	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired Mer Servi	during most of word )	king		6b. Kind of Business/Industry  S Postal Service	
land 2		To Be Co	17. Father's Name (First, Middle, Last)  James L. Simmons	, Sr.	Jazeo	DOLVI	18. Mother's Nam		Maiden Surname)		
			19a. Informant's Name/Relationship (Ty Antoinette Toole 20a. Method of Disposition	/ daughter	1174	ng Address (Street a  Valley S sition (Name of matory or other place	tream Dr	., Perkic		le, P	A 18074
Baltimore,	permit. Pages Department of t Importent: If it eny injury or o		1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Mt	. Calva	ry UM Cem Name and Addres Lisa Sco 552 Lewi	etery 2,				aryland
8760, 2	cate be executed whysician and physician and the burial-transit	dicai Examiner	23a. Pan1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	er the mode of dying dial w	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death
Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3 [	Ectopic pregnancy Other (specify)			23d. Date Mon		y Day Year
rds, P.O.	quires that I in signed by uld be deta	þ	Part II. Other significant conditions con	•	resulting in the u	nderlying cause give	on in Part I.	23e. Did tob	A .		e cause of death?
Vital Records,		Completed						24a. Was an autopsy perform	ed? de	ior to comeath?	sy findings available apletion of cause of
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ▼Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	t 3 DOA Othe	ne-	h <i>(Check only one</i> ome 5 <b>Y</b> Resider		r (Specify)	1
ion of		atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injury Work	at	28d. Describe hov			
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Str. City or Town,		r or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical		sician: To the best of my ner: On the basis of exam and manner stated.							
)	To the l within 2: To the I complet	W	29b. Signature and title of certifier	I.R. Was A	ME	29c. License	number 4206		d. Date signed		
- (	991		30. Name and address of person who/co					BALTO M	d 2123	2.	
	Sta Registi	_	31. Date filed (Month, Day, Year) FEB 1 8 2004	32. Registrar's Si		in di	11, 1/2	14510	C 1100		

State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:35P 2004 Stanley Umstead 29 February, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 6 1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sey 7. Age (In yrs. last birthday) **Funeral** 219-14-8362 85 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD MONTGOMERY BEALLSVILLE 1 Yes 2 No Director 10f Zin Code 10g. Citizen of What Country? 10e Street and Number ms 23a or 7 19700 DARNESTOWN ROAD 20839 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ©Yes 2 □ No1 9 4 3 − If Yes, Give Year or Dates: 1 9 4 6 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Completed by WHITE 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER SERVICE STATION 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Importent: if item 27 is marked other it any injury or other traumatic event, Ita ance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MAURICE UMSTEAD BERTHA KING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REBECCA UMSTEAD/SPOUSE P.O. BOX 34, BEALLSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State FREDERICK CREMAT. 3/3/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Deumania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenfs resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No łō Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Division of Vital Records, δ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 P/Outpatienf 3 DOA ဥ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 5 Pending investigation 1 ☐ Yes 2 📆 No 2 Accident Director: 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen shah 65 -C MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 ▶ Registrar

Unpend Item #23a,27,28a-F per med 829 5/23 Fagure All Copies Are Legit.

Amend Item #283a per dvr 6829 Department of Health and Mental Hygiene 2004 37074

Strar

Certificate of Death

Reg. No. James Walls 04 - 1470For A State Registrar AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5. Time of Death Day Ybair **Physician** James Gordon Walls February 26 2004 11:51 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Director 59 219-44-1729 February 10, 1945 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exemples must be notified at 1 Yes 2 No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 908D Market Street death Funerai 21629 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian Year or Dates: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Care Provider 8 Geriatrics other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) int of Health and Mental Hy t: If itam 27 Is marked oth y or other traumatic sven Be Pages 1 and 2 should be Walls Paul Sarah Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 903, St. Michaels, Maryland 21663 James P. Walls Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F.
Importent: if its
any injury or oit 1 Surial 2 Cremation 3 Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) Ridgely Cemetery 3/3/2004 Ridgely, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Moore Funeral Home, P.A. 21629 11000 12 South Second Street, Denton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Head Injury with Complications /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial physician **Physician Medicai** the as Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ or a 2 □ No 24a. Was an has le autopsy performe 1 Yes 2 certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 □ No 1XXnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury **Fo**(1901), *Day Year*) 2-26-04 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 🗌 Pending death. 1 ☐ Yes 2 XNo unknown M 2X Accident investigation subject fell 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 908 Market St Denton, Mi) 21629 4 Homicide

Director: within 24 hours after To the Funeral Dire To the Hospital

State

29a. Certifier

(Check only

Medical

31. Date filed (Month, Day, Year) MAR

29b. Signature and title of certifie

EDPORE Miking Q2 Registrar's Signature

30. Name and address of person who completed cause of team (Item 23a) (Type, Print)

2004

Found in residence

111 Penn Street, Baltimore, Maryland 21201 Con the A

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) February 28, 2004

			For State Registrar	State of N	/laryland	d / Depa	artment rtificate	of Hea	ith and Neath	Mental Hy	giene Reg. No. 2	004	0.7	075
			Decedent's Name (First, Middle, Las	t)						2. Date of De	aath	*	3. Time of	Death
	Physicia		Grussi	D	Wat	DVC				Feb	04	2004	1210	М
	/Medic Examin		4a. Facility Name (If not institution, give	-			4b. City, To	own, or Loc	ation of Death	1	4c. Co	unty of Death		
	LXaiiiii	C.	Atlantic General	Hospital			Berl	in			Wo	rceste	r	
	Funeral		5. Social Security Number 6. Se	9x 7. /	Age (In yrs. I	ast birthday)	If Under 1 Months	Year If	Under 24 Hrs. lours Min.	8. Date of Bi			place (State o	or Foreign
0	Director		214-32-0336		70	Yrs.	Worthis	Jayo		Mar 1,		V		
70	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						0d. Inside C	ity Limits
1007	shor	7	MD Worceste	ar		omoke								2 No
77	the Marylan 728a-1 show political at	ect	10e, Street and Number	~L	1000	JIIONE	10f. Zip C	ode			10a. Citizer	of What Cou	ntry?	
7	with	ä	1210 Market St., A	Apt. G-3			218					U.S.	,	
	ns 23	era	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13.			nic Origin? (Sp	pecify Yes or No Decify Rican, etc.)		Race - Ameri		
7	r Iter	표	1 ☐ Never Married 2€ Married	Armed Force						o Rican, etc.)		Black, White,	etc.	
23	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2	XNO S	pecify:		Sp	ecify: Bl	ack	
3/1/1933 . 1 <b>21215-0036</b>	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23e or 28e-f show int, the Medical Examination wat be a builded at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	lucation de com <i>pleted)</i>		(Give	dent's Usual (	done durin	n ng most of worl	king	16b. Kind	of Business/In	dustry	
2	ithin Nan	npie	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT use	retired)						
	led w ygier ygier yerth	ខ	12				Dom	estic		ne (First, Middle		Variou	S	
and	eve be	Be	17. Father's Name (First, Middle, Last)								s, maiden Su	name/		
	should be nd Mental markad o	မှ	Willie Smith  19a. Informant's Name/Relationship (	Tuna Printl		10b Mailie	ag Addross /			Baines	or City or To	um State 7is	Code	
SSie 633 Mary	d 2 Tha		Freddie James Wate		ьп		•			moke Ci			Code	
7	s 1 and f Heali item 2 other		20a. Method of Disposition	210/ 11abba			sition (Name natory or oth		1000	Date		ion - City or T	own, State	
~wo			1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		le		n Ceme		2/7/:	2004	Docom	oke Ci	Hu MD	
re.	permit. Page Department of Important: If any injury of ance.		21. Signatur + Funeral Servin Licer		, DCO.	22	. Name and	Address of	f Facility			OKC CI	CY, I'I	
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			23a. Part1. Enter the disease, or colm shock, or heart failure. List only	olications that caus	sed the death	. Do not en	er the mode	of dying, s	uch as cardiac	or respiratory	arrest,	1001	Approximat Interval Bet	e ween
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6	/Medical		resulting in death)	Due to (or	as a consequ	uence of):	91	d	7 000		A	_	- Cu	WS-
	Examiner		Sequentially list conditions.	b	a.	thens	Serit ?	126	ysele.	no (H	ey D	(Segl	14	215
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):			A				1	
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387	icate phys s the			_ d										
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ă	eath atter	ciar	in the past 12 months?	1□Live birth 4□Pregnant			□Ectopic preg □ Other <i>(spec</i>					Month	*	Year
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	ires that the death signed by the atte d be detached for	by P	Part II. Other significant conditions of	ontributing to death	n but not resu	ulting in the u	nderlying cau	use given in	Part I.	23e. Did	tobacco use	contribute to t	he cause of o	death?
ž	w require been sig should b			Gud	Sitry	Ve Ve	nal.	ta.)	<del>/</del>	1 🗆	Yes 2 1	lo 3☐ Prol	ably 4 🗍	Unknown
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ita	ien: artifica ctor,	Be (	25. Was case referred to medical examiner?			- 60000	85			th (Check only				
~	hysic his ca al dire	္	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		€R/Outpatie	-			ome 5 Res			<b>'y</b> )	
_	ding Physicien: The lav h. After this certificate has funeral director, page 2.	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of li (Month,	njury Day Year)	28b. Time o Injury	1 286 M	c. Injury at Work?	2 □ No	28d. Describe	now injury o	ccurred		
sic	ttend death stor:	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e One Diese of	Injury - At ho	me farm st			20110	28f. Location	(Street and N	umber or Run	al Route Num	ıber.
Division of Vital Records,	lor A after Direc	Certification:	4  Homicide determined	building,	etc. (Specif	y)	001, 10010191	011100		City or To	iwn, State)			
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical C	(Check only 2 Medical Exer	ysicien: To the be	s of examina	wledge, deat tion and/or in	h occurred at	t the time, on my opinion	date and place on, death occu	, and due to the rred at the time	cause(s) an	d manner as s	tated.	s)
	thin 2. tha I	Medi	one) 29b, Signature and title of certifier	and manner	stated.		29c	License nu	ımber		29d. Date s	igned (Month,	Day, Year)	
	J N S		De Carlo Triv	1			1	10	110	/	- 1	-12.0		
			30. Name and address of person who	completed cause of	of death (Item	23a) (Tvna	Print)		16/21	<b>-</b>		> 104		
DDQ			TAN, COPSTANTS	(340)	5-01	Vision	st. =	salist	ound ,	MO				
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	Regist	rar	FEB 1 2 20	104	new		ayo	us						

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ox 68760, ₹	certificate be executed	nding physician and use as the burial-transit

Please Type or Print in	Black Indelible Ink.	<b>Ensure All Copies</b>	Are Legible.

			For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment of He tificate of D	ealth and M leath	Re	g. No.	07076
	Physicia	an	Decedent's Name (First, Middle, Last)     D = 1	Cilbant Was				Date of Death     Month	Day Year	3. Time of Death
	/Medic	al		l Gilbert Wag	ner	4b. City, Town, or L	continue of Death	FEBRUAR	Y 18, 2004 4c. County of Death	
	Examin	er	4a. Fecility Name (If not institution, give si VA MARYLAND HEALTI		1		POINT		CECIL	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 54		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 30	9. Birth <i>Cou</i> 1949 Ma	place (State or Foreign ntry) rryland
	2		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	f aho	ō	Maryland		•	ltimore				1 ∑Yes 2 □ No
	7.28a-	Director	10e. Street and Number		ра.	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23a o		3806 Dorchester Ro	ad		2	1215		U.S.	Α.
92	/2 hours after death with the Maryland Instural', or Hema 23a or 28a-f ahow dical Examiner must be notified at	y Funerai	1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1967-	J.S. 13. \	Vas Decedent of His f Yes, specify Cuban I ☐ Yes 2☑ No	panic Origin? (Spo , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: 1	
	tural',	ed by	3 ☐ Widowed 4 ② Divorced  15. Decedent's Educ		16a. Deced	lent's Usual Occupat	ion	1	6b. Kind of Business/Ir	
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מפ	other it.	BeC	17. Father's Name (First, Middle, Last)			1	18. Mother's Name	(First, Middle, M	laiden Surname)	
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Nar	bra mu		19a. Informant's Name/Relationship (Type Erin Reinhart, Eligibil		3	•			City or Town, State, Zi	
	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of			Oc. Location - City or T	
ē	00===		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	amoval from State		natory or other place; brest Cemete:		6/04 C	wings Mill	s, Maryland
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	enema Sc					ral Home,	P.A.
	2	П	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dea	th. Do not ent	erryville, er the mode of dying,	Marylan such as cardiac	d 21903 or respiratory arre	<del>-0/66</del> st,	Approximate Interval Between
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	ath certifi titending or use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregn 1 Live birth 2 Fett 4 Pregnant at time of 6	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	ery Day Year
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ds,	uires l signe	d by	•					1 🗆 Ye	s 2□No 3□Pro	bably 4 💆 Unknown
Records,	sw requir s been s s should	olete						24a. Was an		opsy findings available
Re	The lav	Completed						autopsy perform 1 Yes 2		·
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					n (Check only one	)	
<b>d</b>	S 5	은	1 ☐ Yes 2 💢 No	ospital: 1X Inpatient 2	28b. Time of		4   Nursing no	me 5 Resider	nce 6 Other (Speci	fy)
	ding After funer	tlon	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work?	es 2 🗆 No	204. 20301120 110	windly coodings	
ā	f or Attending after death. Director: Aftel In by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui , State)	al Route Number,
	To the Hospitel or Attence within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		ician: To the best of my kn ter: On the basis of examin and manner stated.						
	To the Within To the somple	Me	29b. Signature and title of certifier	/ //	/ /	29c. License	number	29	d. Date signed (Month	Day, Year)
			1	ands 12	anda	D42	2800	E	ebruary 18	, 2004
	1		30. Name and address of person who co	mpleted cause of death (Ite			2112			
	1		THOMAS BIONDO, M.				SYSTEM,	PERRY PO	INT, MD 219	902
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature					

	1.	State Registrar			Ce	rtifica	te of L	Death			Reg. No.	600	4 0707
ician		Decedent's Name (First, Middle, L John Anthony								2. Date of D Month	eath Day	Year	
dical		. Facility Name (If not institution, g		harl		4h City	Town or	Location of	of Death	March	2 20	0.4 County of Dea	3:05AM
niner	40			1001)		,							
al			. Sex	7. Age (In yrs.		If Unde Months		If-Under Hours	24 Hrs. Min.	8. Date of B	irth	llegan,	rthplace (State or Fore
or	1_	010-20-7044	1 <b>⊠</b> M 2□F	7	9 Yrs.	Months	Days	riouis		Mar 1	2,19	24 Mas	ssachuett
à		sual Residence of Decedent  Da. State 10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Lim
ţ	M	Maryland Alle	egany	F	rostb	ura							1 <b>∑</b> Yes 2 🗀 î
Director	10	De. Street and Number					p Code			-	10g. Citi	zen of What C	Country?
a D		85 Pine Stree	et			2	2153	2				USA	
Funeral	11	I. Marital Status	12. Was Dece Armed For	ces?	J.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	ispanic Ori n, Mexican	gin? (Sp	ecity Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh	
by Fi		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 [XXYes If Yes, Give Year or Da	9 TATTAT	II	1 🗆 Yes	2 <b>☑</b> No	Specify:				Specify: V	White
ed		15. Decedent's	Education	ites.	16a. Dece	dent's Usu	ual Occupa	ation			16b. Ki	nd of Busines:	s/Industry
Completed	-	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-	-40r 5+\	(Give	kind of wi DO NOT L	ork done o	turina mos	t of work	ing			<b>,</b>
E O		12	oonogo (1		Pri	nter					T	extile	e
B	17	7. Father's Name (First, Middle, La	ist)							e (First, Middle		Sumame)	
ို	1	Frank Zaloga					and the second	_		ne Jar			
		9a. Informant's Name/Relationship Muriel Zaloga										Town, State,	Zip Code)
	11	Da. Method of Disposition		20b. I	Place of Dispe	osition (Na	me of			burg,		21532 cation - City o	r Town. State
		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		State Si	cemetery, cre lbaugl	matory`or	other plac emat		Mar				
	2	Signature of Funeral Service Lice		^ ~	2	2. Name a	nd Addres	s of Facilit	tv	2004		ontowr	i, PA
Succession			LL.	V	I	lafe	r Fu	nera	1 S	ervice	P. P.		21502 Approximate
n al	d	mmediate Cause (Final lisease or condition esulting in death)	_a Arteri	oscler	N . 12								Onset and Death
dical Examiner	re	iequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Uisease or injury nat indiated events seulting in death) Last	b	or as a consec or as a consec or as a consec	quence of):	eart	dise	ase					uk yrs
dical Examiner	re	iai initiated events	b	or as a consector as	quence of): quence of): quence of): unancy al death 3[	Ectopic p	pregnancy					23d. Date of de Month	
by Physician/Medical Examiner	IF 2	FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	b. Due to (c. Due to (c. d. 23c. If yes, outc. 1   Live bi 4   Pregna 9   Unknown	or as a consector as	quence of):  quence of):  quence of):  ancy al death 3[ death 5[	□Ectopic ρ	pregnancy				tobacco u	Month se contribute t	blivery Day Year to the cause of death?
by Physician/Medical Examiner	IF 2	FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	b. Due to (c. Due to (c. d. 23c. If yes, outc. 1   Live bi 4   Pregna 9   Unknown	or as a consector as	quence of):  quence of):  quence of):  ancy al death 3[ death 5[	□Ectopic ρ	pregnancy					Month se contribute t	blivery Day Year to the cause of death?
leted by Physician/Medical	IF 2	FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	b. Due to (c. Due to (c. d. 23c. If yes, outc. 1   Live bi 4   Pregna 9   Unknown	or as a consector as	quence of):  quence of):  quence of):  ancy al death 3[ death 5[	□Ectopic ρ	pregnancy			1 24a. Wa	tobacco u	Month se contribute t  No 3 ☐ P	Day Year to the cause of death? Probably 4 Unknown
Be Completed by Physician/Medical Examiner	Pro	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant conditions  Renal failure	b. Due to (c. Due to (c. Due to (c. d. Due t	or as a consector as	quence of):  quence of):  quence of):  lancy al death 3[ death 5[ sulting in the c	⊒Ectopic p □ Other (s underlying	pregnancy pecify) cause give	en in Part I.	of Death	24a. Wa autr per 1 Yes	tobacco u Yes 2[ s an opsy ormed? 2 No	Month se contribute t No 3 P  24b. Were a prior to death? 1 Ye	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings availate completion of cause of
To Be Completed by Physician/Medical Examiner	Per 2:	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant conditions  Renal failure  5. Was case referred to medical examiner?  Yes 2 No	b. Due to (c. Due to (c. Due to (c. d. Due t	or as a consector as	quence of):  quence of):  quence of):  lancy al death 3[ death 5[ sulting in the colored	□Ectopic p □ Other (s) underlying	oregnancy pecify) cause give	en in Part I. 26. Place er: 4 ∐ Nu	of Death	24a. Wa auto per 1  Yes	tobacco u Yes 2 s an ppsy ormed? 22 No one)	Month se contribute to No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Spe	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings availate completion of cause of
To Be Completed by Physician/Medical Examiner	Per 2:	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions: Renal failure  5. Was case referred to medical examiner? 10 Yes 2 No 10 Name of Death 12 Natural 5 Pending	b. Due to (c. Due to (	or as a consector as	quence of):  quence of):  quence of):  lancy al death 3[ death 5[ sulting in the c	□Ectopic p □ Other (s) underlying	oregnancy pecify)	en in Part I. 26. Place er: 4 ∐ Nu	of Death	24a. Wa autr per 1 Yes	tobacco u Yes 2 s an ppsy ormed? 22 No one)	Month se contribute to No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Spe	Day Year  to the cause of death?  Probably 4 Unknow autopsy findings availate completion of cause of
To Be Completed by Physician/Medical Examiner	Per 2:	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1	b. Due to (c. Due to (	or as a consector as	quence of):  quence of):  quence of):  quence of):  ancy al death 3[ death 5[ sulting in the continue of the c	Ectopic c Other (s underlying	oregnancy pecify)  cause give	an in Part I.  26. Place ar: 4 □ Nu / at	of Death	24a. Wa auto per 1	tobacco u Yes 2[ s an appropriate of the company of	Month se contribute to No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Spa	Day Year  to the cause of death?  Probably 4 Alunknov autopsy findings availat completion of cause of
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To Be Completed by Physician/Medical Examiner	Fe   2:	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown    art II. Other significant conditions:  Renal failure  5. Was case referred to medical examiner?  1. Yes   2   No    7. Manner of Death   1. Disturbed    1. Disturbed   1. Disturbed    2   Accident   3   Suicide   4   Homicide    29a. Certifier   Check only   Medical Ex	b. Due to (c. Due to (	or as a consector as	quence of):  quenc	DEctopic property of the courrect westigation	OA Other	26. Place ar: 4 □ Nu / at ?? Yes 2 □ i	e of Death	24a. Wa autrepent 1 Yes of Check only me 5 Res 28d. Describe 28f. Location City or To	Yes 2[ s an posy ormed? 22 No one) idence ( how injur (Street ani wm, State, e cause(s), date and	Month se contribute t No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Special Control of the	Day Year  To the cause of death?  Probably 4 Unknow  Autopsy findings availab  completion of cause of  s 2 No  Probably Autopsy findings availab  completion of cause of  s 2 No
edical Certification: To Be Completed by Physician/Medical Examiner	Fe   2:	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown    art II. Other significant conditions:  Renal failure  5. Was case referred to medical examiner?  1. Yes   2   No    7. Manner of Death   1. Death   1	b. Due to (c. Due to (	or as a consector as	quence of):  quenc	Dectopic production of the occurrective stigation 29	OA Other Control of the time of time of the time of the time of the time of time of the time of ti	26. Place er: 4 \( \) Nu / at / 27 Yes: 2 \( \) ine, date an  pinion, dea	e of Death	24a. Wa autrepent 1 Yes of Check only me 5 Res 28d. Describe 28f. Location City or To	tobacco u Yes 2 [ s an ppsy ormed? 2 No one) idence 6 how injury (Street ann wm, State, c cause(s), date and	Month se contribute t No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Special Control of the	Day Year  to the cause of death?  Probably 4 Unknow  autopsy findings available completion of cause of secretary.  Bural Route Number,  as stated.  te to the cause(s)

		1	For State Registrar	State of Man			te of Death		Reg. No. 200	
ı	Physicia		Decedent's Name (First, Middle, Last  DET XIA			TD A 1	KER	2. Date of De Month	Day Yes	
	/Medic		BELVA  4a. Facility Name (If not institution, give	Street and number)			Town, or Location of Deat	Februa	4c. County of D	
	Examin	er	Wicomico Nursing			Sal	lisbury		Wicomic	
A-1.	Funeral		5. Social Security Number 6. Se	x 7. Age (/	In yrs. last birthday	If Unde Months	r 1 Year   If Under 24 Hrs   Days   Hours   Min.	. (Month, Da	th 9.	Birthplace (State or Foreign Country)
١.	Director	-	216-01-3915	JM 243-F	93 Yrs.			OCT. 12	2, 1910	MARYLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	tor	MARYLAND WICOMIC	co	PITTS	VILLE				1X Yes 2 No
	or 28	Director	10e. Street and Number			1	p Code		10g. Citizen of What	Country?
	s 23a		WEST STREET	12. Was Decedent Eve	ar in II S 13		21850	Specify Yes or No	USA 14. Bace - A	merican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant, the Medical Examples may be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Amed Forces?  1 Yes, 22 No If Yes, Give Year or Dates:	ar in 0.3.	If Yes, spe	dent of Hispanic Origin? (Socity Cuban, Mexican, Puer 2 No Specify:	to Rican, etc.)	Black, W	Vhite, etc. WHITE
8	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	edent's Ust	ial Occupation ork done during most of wo	nrkina	16b. Kind of Busine	ess/Industry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT	AMSTRESS	and a	GARMI	ZNT
	filed w Hygiel other ti	Co	12 17. Father's Name (First, Middle, Last)			01.		me (First, Middle	, Maiden Sumame)	
Maryland	Aental Aental rked o	To Be	EDWARD	WHITE			MARY		JACKSON	
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ling Addres	s (Street and Number or R	ural Route Numb	er, City or Town, Stat	re, Zip Code)
	1 and 2 Health tam 27 i		JANET DONAWAY/NI		608 20b. Place of Disp		ROAD, SALIS	BURY, MA	RYLAND 218	
Baltimore,	permit. Pages 1 and Department of Healingortant: If itam 2 any injury or other once.		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or	other place)			
턡	artmer ortant injury		*4 □ Donation 5 □ Other (Specify  21. Signature of Fulleral Service Licen				CEMETERY 2/ nd Address of Facility	19/04	PITTSVI	LLE, MID
Ba	Deparent Important Important Irraportant I		1 Charles W	Hurs			GS FUNERAL H			DE. 19975
	*		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	e death. Do not er	nter the mo	de of dying, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a DEHY	DRATIO	N				
	/Medical Examiner			Due to (or as a o	consequence of):	77	DEMEA	TIA		
	- 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	consequence of):	15	V C IVIEN	V 1. 7. !		
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	eath certificate be executed attending physician and for use as the burial-transit	a Ex	leading in douting cast	Due to (or as a o	consequence of):					
687	ficate g phys	edical	•	d						
Вох	iaw requires that the death certif as been signed by the attending 2 should be detached for use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic :	pregnancy		23d. Date of Month	delivery Day Year
Э. В	ne deal the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	Other (s	specify)		MORE	Day
P.0.	res that the de igned by the be detached		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying	cause given in Part I.	23e. Did	tobacco use contribut	te to the cause of death?
rds	quires n sign uld be	ed by	OSTEDPOROS	S				10	Yes 2□No 3□	Probably 4 Winknown
of Vital Records,	e law requir has been si je 2 should l	Completed						24a. Was	s an 24b. Were	e autopsy findings available to completion of cause of
æ	The ate ha	Com						perf 1 ☐ Yes	ormed? deat	h? Yes 212 No
/ita	Phyaician: The certificatal director, p	Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check only		
of	Physic rthis ral dir	To :	1 Yes 2 No	28a. Date of Injury	2 ☐ ER/Outpation		28c. Injury at Work?		how injury occurred	Specify)
0	Attending ir death. ector: After by the fune	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Division	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		street, facto	ry, office	28f. Location City or To	(Street and Number o own, State)	r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C			xamination and/or		d at the time, date and place on, in my opinion, death occ			
	To the To the Complex	Me	29b. Signature and title of certifier			2	9c. License number		29d. Date signed (M	fonth, Day, Year)
			Malul	nll.	M		D 0060	5/5	2/16/	04.
1			30. Name and address of person who Mahesha Thimmara		ath (Item 23a) (Type 504 Easte		re Dr Salis	bury MD	21804	
(V)	St	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	,	books			
	Regist		FEB 1 9 2	004 Sens	D	19	vous			

		1	For State Registrar	State of Mary	land / Depa	artment of I rtificate of	lealth and Death	R	eg. No.	4	07079
	Dhusiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		ear	3. Time of Death
	Physicia /Medic	al -	LEONILDA		BARREIRO			Feb.		204	18:14PM
	Examin	G1	te. Facility Name (If not institution, give si Peninsula Region.	u Medica	H Center	4b. City, Town,	Stury  If Under 24 F		4c. County of Wice	nic	ace (State or Foreign
	Funeral Director		11/-24-4415	M 2 🔏 F	90 Yrs.	Months Days		JAN. 3,	, Year)	Counti	PAIN
	deeth with the Maryland ms 23a or 28a-f show frats te notified at		Usuel Residence of Decedent  10a. State  10b. County	10	c. City, Town or Lo					10	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	Ne M	Director	DELAWARE SUSSEX  10e. Street and Number		SELBYVI	10f. Zip Code		1	0g. Citizen of Wh	at Count	ry?
	with t		26 BLUEBILL DRI	JE.		199	75		USA		
	leeth ns 23	era		2. Was Decedent Eve	r in U.S. 13.			(Specify Yes or No- uerto Rican, etc.)			
936	or Its	by Funerai	1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, sp <i>ec</i> ify Cub 1 X Yes 2 □ No	Specific	SPANISH	Specify:	White, e	
215-0036	C	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. Kind of Busin		
2121	filed within Hygiene. Sther then sent, the Menter the M	Con	8			FARMER	1 40 44 4 4	N	AGRICUI		<u> </u>
Maryland	S ta b	To Be	17. Father's Name (First, Middle, Last)  MANUEL	PUENTE			ADEL	Name (First, Middle, AIDA	CAMPO	os	
Mary	コトトサ		19a. Informant's Name/Relationship (Type JESUS BARREIRO/SON	e, Print)		•		r Rural Route Numbe SELBYVILLI			Code)
ē,	of Heal	1 8	20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - Ci	ty or Tov	vn, State
E	Page nent c ant: If arry or		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	ST. RAYM	ONDS CEMI	ETERY 2	2/21/04	BRONX, I	NEW .	YORK
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 sny injury or other 20058.		21. Signatura of Funeral Service License	Hurt	H.		UNERAL	HOME, SELI		DE.	19975
	Physician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the cause on sach line.	Teath. Do not en	ter the mode of dy		c respiratory and			Approximate Interval Between Onset and Death
3760,	/Medical Examiner  physicien and physicien a	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ATK	onsequence of): onsequence of): onsequence of):	TbRi	llati	ing.			
P.O. Box 6	Physician: The law requires that the death certalicate be executed this certalicate has been signed by the atterding physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 [ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pregnan ⊒ Other (specify)	су		23d. Date Monti		ry Day Year
	uires that the de signed by the id be detached	by	Part II. Other significant conditions con	tributing to death but n	not resulting in the	funderlying cause g	iven in Part I.		bacco use contrib 'es 2□No 3	oute to the	1/
of Vital Records,	e law requir has been si je 2 should l	Completed	Anti S	Hnosis				24a. Was autop	an 24b. We sy pri rmed? de	ere autop or to con ath?	psy findings available appletion of cause of
1	r: The		Myocard	ial IX	tract	2001			2 No   1L	Yes	2□ No
V SEE	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatie	nt 207004 0	ther	Death (Check only on ng Home 5 ☐ Resid		(Specifi	-
	ding Physician: The n. After this certificate his funeral director, page	To To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day Y		of 28c, Inj	ury at		ow injury occurred		/
, e	Attending Frideath.  Cotor: After by the funer.	atior	1 Accident 5 Pending Investigation	(Month, Day Y	ear) Injury		ork? ⊒Yes 2.⊟No				
Division	after death.  Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, s Specify)	treet, factory, office	9	28f. Location (S City or Tou	Street and Number m, State)	or Rura	Route Number,
,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical C	29a. Certifier A Certifying Physical Control (Check only one)	sician: To the best of r ner: On the basis of ex and manner state	camination and/or i	th occurred at the nvestigation, in my	time, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) and mand date and place, an	ner as standard	ated. the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier	^		29c. Lice	nse number		29d. Date signed	(Month, I	Dey, Year)
			The state of	- U lar	)	1	3476	08	0/18	101	4
^			30. Name and address of person who co	mpleted sause of dear	th (Item 23a) (Type	, Print)	-/ -	disbury,	22.5	100	<b>\</b>
DB	\		Jettery W	ieland 1	00 E. C	arroll.	St. Su	USBUTY,	MD a	1180	//
	St Regis	ate	31. Date filed (Month, Day/Year) FFR 1 9 20	32. Registrar's	Signature	Spar	les	,			

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year BLACKBURN 2004 /Medical 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MEDICAL PENINSUUA 5AL156412 NICOMICO CONTOR 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 207-24-0880 PRIL 5,1933 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at 1K Yes 2 No Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31912 MT. HERMAN ROAD Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MANAGER PUBLICATIONS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, 9069. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS BLACKBURN MARIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL A. BLACKBURN- WIFE 31912 MT. HERMAN RD SALISBURY, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 2/18/2004 DELMAR, DE 21. Signature of Funeral Service Licer 22. Name and Address of Facility BOUNDS FUNERAL HOME -sall 705 E MAIN STREET SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause Final disease or condition resulting in death) Septie Shock Physician /Medical Due to (or se a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause from the cause of closease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician a for use as the burial-IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Colon Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed CAD. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD 1 Yes 1 Yes 2□ No 2/2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₽No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 14 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide peli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier mpletely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 229105 Myradel Son 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbry, 10 2/80/ Nistin 31. Date filed (Month, Day, Year) FEB 19 32. Registrar's Signature State Registrar

			For Stete Registrar	State of Marylane		t of Health and le of Death		2004	07081
	Physici /Medio Examin	an :al er	1. Decedent's Name (First, Middle, Last Dora Eliza de Lastera de L	beth Brown street and number) St APT 110	4b. City,	Town, or Location of Deat		Day Year  12 - 04  4c. County of Peath  Will Colmi	cò
	Funeral Director		5. Social Security Number 6/S 244-52-2/69  1 Usual Residence of Decedent	9X 7. Age (In yrs. I	Yrs. Months	Days Hodrs Min.	8. Date of Birth (Month, Day, )	(ear) 9. Birth Co.	place (State or Foreign
	Ba-f ehow	ctor	10a. State 10b. County  MD WICOM	10c. City	y, Town or Location Sall, 564 r	9			10d. Inside City Limits 1 Yes 2 □ No
	eeth with the 23a or 24	Funeral Director	10e. Street and Number 939 GaTeway	S+ Ap+ //c	10f. Zip	1801		2. Citizen of What Cou	·
2-0036	ours after de ral', or Item Examinate	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?  1  Yes 2 N No If Yes, Give Year or Dates:	If Yes, spec	dent of Hispanic Origin? (Scriy Cuban, Mexican, Puer No Specify:	to Rican, etc.)	Black, White	
2121	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wo life. DO NOT us WORK	rk done during most of wo se retired)	rking	Sb. Kind of Business/II	
Maryland	should be filed nd Mental Hygio marked other umatic event, II	To Be (	17. Father's Name (First, Middle, Last) Clarence Ha	11150N		18. Mother's Nat	ne (First, Middle, Ma	uiden Sumame)	)
	1 and 2 sho Health and I em 27 le me		19a. Informant's Name/Relationship (	Type, Print) SU-DAUGHTAZK	19b. Mailing Address 28932 S	(Street and Number or Re	iral Route Number, C	1.	o Code) 5-6
altimore,	Pages 1. nent of He int: If iten iry or oth		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 5	Removal from State	lace of Disposition (Nar emetery, crematory or o		Date 20	C. Location - City or T	own, State
Balti	permit. Pag Department Important: any injury o	4	21. Signature of Funeral Service Licer	See /		nd Address of Facility Be	Aniesm 51-51	14 F/H	21801
1760,	Physician /Medical Examiner physicien and physicien and physicien and physicien and physicien are physician at the physician are p	ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)   wence of):  Wornt  Wence of):	le of dying, such as cardia	c or respiratory arres	1. //	Approximate Interval Between Onset and Death	
P.O. Box 68	Attending Physician: The law requires that the death certifica rideath. rdeath. ector: After this certificate has been signed by the attending phy the tuneral director, page 2 should be detached for use as it by the tuneral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3 Ectopic pr			23d. Date of deliving Month	ery Day Year
	quires thet n signed b	ed by Pr	Part II. Other significant conditions of	1	ulting in the underlying c	ause given in Part I.		cco use contribute to 2 ☑ No 3 ☐ Pro	the cause of death?
Division of Vital Records,	n: The law requir icate has been si r, page 2 should	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Z Z	ysiclar is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DC	Other	ath (Check only one) dome 5 Pesiden	ce 6 □Other (Spec	(fv)
o uo	iding Ph th. : After th tuneral	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	9 28a Place of Injury - At he	ome, farm, street, factory	y, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir. completely filled in I	edical	29a. Certifier 1	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occu	e, and due to the cau arred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		290	c. License number	290	I. Date signed (Month)	Dey, Year)
1				M;	)	SILDMIL		2718/0	1
			30. Name and address of person who Steven Hearr	completed cause of death (Item	RD St. S	salisbury	14d 218	(01	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 9 20	32. Registrar's Signa	ture & So	aks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day **Physician** hristine V. 16,2004 /Medical 5:20 PM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number, Examiner Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral**  Birthplece (State or Foreign Country) Months Days 1□M 200 F 217-28-4942 Usuel Residence of Decedent Director 10a. State 10c. City. Town or Location 10d. Inside City Limits Wicomico MD **Funeral Director** Vaskin 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 432/ Typskin - Nonticoke 21865 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2⊠ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2□No Specify: Specify: BIACK To Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Department of Haalth and Mantal Hygiene. Important: If Item 27 is marked other than College (1-4or 5+) Jeafood 12th Grade ine worker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Olivia Conway Grant S. Long 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4321 Tyeska-NANTicke Rd-Tyoskin Md 21865 WANDA Hull-Dall Tier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removal from State 2/22/04 4 ☐ Donation 5 ☐ Other (Specify) NewTown Cemeter Tyaskin 21. Signature of Funerel Service Licensee 917 W. Isabella St - Salisbury 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical week Examiner Due to (or es a consequence of). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown aweus Be Completed by ours after death. •••• Divector: After this certificate has been signe filled in by the funeral director, page 2 should be r 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? me [] -2 No hypertension Sireaci 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 70853 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Registrar

DHMH 16 Rev 6/95

B. Silvia

FEB 1 8 2004

31. Date filed (Month, Day, Year)

MV

32. Registrer's Signature

CHRISTINE VALERIE BOYKIN

souls

1346 S. Division St.Suite, Salisbury, Md.21804

			1 - For State Registrar			partment of ertificate of			g. No. 200	4 07083
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Las     OLIVER  4a. Facility Name (If not institution, give	WENDELL	E	SUNTING 4b. City, Town,	or Location of D	2. Date of Death Month Coruant	Day Yea	4 1735 M
	Funeral		5. Social Security Number 6. Se		Vental yrs. last birthda	JAN 1 Under 1 Year		Hrs. 8. Date of Birth	NICON	
ł.	Director		205-14-6108 19 Usual Residence of Decedent	M 2□F	79 Yrs.	Months Days	Hours A	Hrs. 8. Date of Birth (Month, Day, OCT. 14,	1924	Birthplace (State or Foreign Country) DELAWARE
	ne Maryland 8e-f show	Director	10a. State 10b. County  DELAWARE SUSSEX	10	c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 2		10e. Street and Number  RD 2 BOX 58			10f. Zip Code 1997	5	10	g. Citizen of What USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if Item 27 is marked other then "netural", or items 23a or 28e-f show importents if Item 27 is marked other then "netural", or items 23a or 28e-f show injury or other treumatic event, the Medical Eventies must be notified and once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 194		. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🗓 No		? (Specify Yes or No- uerto Rican, etc.)		nerican Indian, nite, etc. WHITE
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	led with lygiene rer the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		ARTS MANA	,		AUTOMOE	SILE
Maryland	should be fit nd Mental H i marked off imatic even	To Be	17. Father's Name (First, Middle, Last)  ALVIN  19a. Informant's Name/Relationship (T)	BUNTING	405.14		FLO	Name (First, Middle, M DRENCE	TOWNS	
, Ma	and 2 sho ealth and m 27 is m		WENDELL BUNTING/SO					r Rural Route Number,		
Baltimore,	Pages 1 nent of He ont: If Iten Iry or oth		20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	cemetery, cri	osition (Name of omatory or other pla	1		Oc. Location - City of	LE, DELAWARE
Balti	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Licens		2	2. Name and Addre	ess of Facility	HOME, SELB		
	Physician /Medical Examiner	7	23a. Part1. Enter the assease, or compositions shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a col	ndNia	iter the mode of dyi	ng, such as card	diac or respiratory arres	st,	Approximate Interval Between Onset and Death Alay S
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	ten	05,5				Years
.O. Box 6	at the death certific. by the attending pl tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
ords, P.	The law requires that the te has been signed by the vage 2 should be detached.	þ	Part II. Other significant conditions con	stributing to death but no	t resulting in the	underlying cause giv	ven in Part I.			to the cause of death?  Probably 4 □Unknown
Vital Records,		Completed						24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of s 2 No
ot VII	din d	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 (Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth		Death <i>(Check only one)</i> G Home 5  Residen	ce 6 FlOther (Sp	acity)
	Attending Pt r death. sctor: After th by the funeral	ertification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	f 28c. Injur Wor	ry at rk? Yes 2 □ No	28d. Describe how	injury occurred	oc.ny)
S	- 9	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - , building, etc. (Sp.	pecify)			City or Town,	State)	lural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinations	sician: To the best of my ser: On the basis of exar and manner stated.	knowledge, deal mination and/or in	h occurred at the tir vestigation, in my o	me, date and pla pinion, death oc	ace, and due to the cau courred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	vithin To th	Σ	29b. Signature and title of certifier			29c. Licens		290	. Date signed (Mon	th, Day, Year)
1	DIA		30. Name and address of person who can FERNANOO	1. We m	(Item 23a) (Type,	Print)	41211		2/20/04	
į	Sta Registra	te	31. Date filed (Month, Day, Year) FEB 2 3 20	32. Registrar's S	ignature	E CAR	eroll.	ST SALI	SOUM	M5 21801

	\$		1 - For State Registrer	State of Maryland / [	Department of Health and Certificate of Death	Mental Hygier	•
			1. Decedent's Name (First, Middle, La	ast)		2. Date of Death	3. Time of Death
	Physici /Medi		Raymond C	Glendon Burke		Month 3	2664 6:14 A M
	Examir		4a. Fecility Name (If not institution, gr	ve street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death
		-8		RT HOSPITAL	CUMBERLA		ALLEGANY
e set u	Funeral Director			Sex 7. Age (In yrs. last bird 73	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign County) MD
	land land		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	the Mary 28a-f eh	ector	MD Allega	ny Cu	ımberland	10	Y□Yes 2□No
	with a or 3	ä	802 Fayette Stree	t	10f. Zip Code 21502	10g.	Citizen of What Country? USA
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S.		Specify Yes or No-	14. Race - American Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 ehow ha Madical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1954-1958	13. Was Decedent of Hispanic Origin? (solid Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: white
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121	within ane. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	Designer	Tire	e Company
N	filed Hygid ther ant,		17. Father's Name (First, Middle, Las.			me (First, Middle, Maid	
an	buld be filed with Mental Hygiene. arked other than atic event, the	To Be	Raymond Henry	/ Burke		Roach Burke	,
Maryland	2 sh and lem	-	19a. Informant's Name/Relationship Sheila Cecil	(Type, Print) 19b. daughter H	Mailing Address (Street and Number or R	ural Route Number, Cit Points	y or Town, State, Zip Code) WV 25437
ē,	s 1 and of Health item 27 other tr		20a. Method of Disposition		Disposition (Name of y, crematory or other place)	Date 20c.	Location - City or Town, Stete
E	Pages nent of l ant: If its ary or o		1 Burial 2 □ Cremation 3 [  '4 □ Donation 5 □ Other (Speci	Theilional Iloili State Docky C	ap Veterans Cemetery	3/5/2004 FI	intstone MD
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service Lice	Aplu	<sup>22. Name and</sup> Addies of Facility Scarpelli Funeral H 108 Virginia Avenu		I MD 21502
<b>17</b>	Physician /Medical		23a. Part1. Epier the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications hat caused the death. Do not cause on each fine.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
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0,0	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequence of	of):		
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89 x	ertifica ling pl	Med	IF FEMALE:				
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<u>Р</u> .	that the de led by the a detached			contributing to death but not resulting in	the underlying cause given in Part I	23e Did tobacco	o use contribute to the cause of death?
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		Completed by				24a. Was an autopsy performed?	
Ž.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	
of	Phys r this ral di	- To	1 Yes 2 No	Inpatient 2 ER/Out	patient 3 DOA 4 Nursing P	fome 5 Residence	
O	ding th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) In	njury Work? M 1 □ Yes 2 □ No	200. Describe flow in	ary occurred
Division	Atten ar deal ector: by the	Certification;	3 Suicide 6 Could not to	28e. Place of Injury - At home, far			and Number or Rural Route Number,
ō	ital or rs afte al Dir	Cert	- CITOLONG	building, etc. (Specify)		City or Town, Sta	iie/
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	, death occurred at the time, date and place Vor investigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
)			MASS	N MD	D54756	MA	ARCH 3, 2004
	/		30. Name and address of person who	completed cause of death (Item 23a) (	T D		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	0		Robert RAPP	912 Seton [	Drive, Cumberlar	id mo à	21502
TON Just	Sta Registr		31. Date filed (Month, Day, Year)  MAR	9 2004	de Santes		

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** February 17 Ac. County of Death WILLIAM HARVEY **CCFFTN** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PONINSULA NICOMICO 541/3644 If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplece (State or Foreign Country) Days 1**√** M 2∏ F 219-88-7523 Director 34 April 15,1969 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be itied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Estimitational be notified at aging. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Hayward Ave Completed by Funeral 21826 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 n/a Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Granville L. Coffin Betty Quillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Hastings/sister 304 Wyman Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 2/20/04 Salisbury, MD Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed AB and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Dete of delivery 3 Ectopic pregnancy ŏ in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERN SHORE DRI 4hmad Namme 400 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 1 9 2004 FEB Registrar

william Coffee

Physician (Medical Beaniner As Fathy Name (Front institution) plus steed and number?  Denmett Road Manor Nursing Home  Oakland  O	ent of Health and Mental Hygiene rate of Death Reg. N 2004 07086	d / Department of h Certificate of	State of Marylan	For State Registrar			
Cuppert Sealing Name (or presentation, presentation and number)  Dennett Road Manor Nursing Home  Dennett Road Manor Nursing Home  Oakland  S. Sood Sealing Name of 9 seals  100 Home 1 7 / 200 ftm, name of management of 100 Home 1 1			st)		oia-	Dhuais	
Dennett Road Manor Nursing Home  Oakland  Oaklan		Cuppett	Upton	Thomas		•	
Secretary Name and Property Name   Part   Control   Co					iner	Exami	
Qualification of Decaders   100. City, Town or Location   100   20   215   50   100   20   20   20   20   20   20							
100 Centry   100	nder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)  JULY 12 1937  9. Birthplace (State or Foreign Country)  MARYLAND	Months Days	TO WOOD	215-38-9696			
THOMAS GLENN CUPPETT    196, Informatic Name/Relationship (Type, Print)   196, Mailing Address (Sweet and Number or Flural Route Number, City or Town, Sate, 2); Co. Carole Cuppett — wife   786 BRAY SCHOOL ROAD OAKLAND, MD 21550   20a, Mandor of Disposation (Parmy of Green)   21 Co. Caroline City or Town, Sate, 2); Co. Sate of Disposation (Parmy of Green)   21 Co. Caroline City or Town, Sate, 2); Co. Sate of Disposation (Parmy of Green)   20a, Mandor of Caroline City or Town, Sate, 2); Co.	10d. Inside City Limits	y, Town or Location	10c. City			and *	
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THOMAS GLENN CUPPETT    196, Informatic Name/Relationship (Type, Print)   196, Mailing Address (Sweet and Number or Flural Route Number, City or Town, Sate, 2); Co. Carole Cuppett — wife   786 BRAY SCHOOL ROAD OAKLAND, MD 21550   20a, Mandor of Disposation (Parmy of Green)   21 Co. Caroline City or Town, Sate, 2); Co. Sate of Disposation (Parmy of Green)   21 Co. Caroline City or Town, Sate, 2); Co. Sate of Disposation (Parmy of Green)   20a, Mandor of Caroline City or Town, Sate, 2); Co.	f work done during most of working	(Give kind of work done)			ete	72 h 72 h	,
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CALCUSE Capped to September 200 Mark And D. Are a consequence of the september 200 Mark And D. Are a consequ		19b. Mailing Address (Street	Турө, Print)	19a. Informant's Name/Relationship	-	shound Mind Mind Mind Mind Mind Mind Mind Mi	3
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Sequentially list conditions, and light properties of the past 12 months?    Sequentially list conditions, and light properties of the past 12 months?   Due to (or as a consequence of):	mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Adays		one cause on each line.	Immediate Cause (Final	n	Physician	
Sequentially ist conditions   Sequentially ist conditions   Due to (or as a consequence of):	Julys	uence of):	Due to (or as a consequ	resulting in death)			П
The part of the pa		Jence of		Sequentially list conditions,			
Section   1998   1998   1999		ience ory.	200 10 (0) 43 4 00113040	cause. Enter Underlying Cause (Disease or injury	T E	uted I Insif	
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		Jence of):	Due to (or as a consequ		Exa	exection and ital-tra	Ċ,
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1			d		cal	ite be nysicia ne bur	9/
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)				IE EEMALE:	Med	ntiffica ng ph	Õ
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25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	(specify)	ath 5 ☐ Other (specify) _		1 ☐ Yes 2 ☐ No	ysic	the de	- 0
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	ng cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	ulting in the underlying cause giv	ontributing to death but not resu	Part II. Other significant conditions		fhat t	
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown					en sign	rds
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, D0025759  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			r accident			n: Th ficate n, pag	ä
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, D0025759  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		EB/Outpatient 30 DOA Oth	Hospital:	examiner?	m	sicie certi	Ξ
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, D0025759  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	28c. Injury at 28d. Describe how injury occurred	28b. Time of 28c. Injur		27. Manner of Death		g Phy er this	Ö
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ed at the time, date and place, and due to the cause(s) and manner as stated.  ion, in my opinion, death occurred at the time, date and place, and due to the cause(s)	wledge, death occurred at the tir ion and/or investigation, in my o	niner: On the basis of examinat	(Check only 2 Medicel Exa	edical	he Hosp in 24 hou he Fune pletely fi	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29c. License number 29d. Date signed (Month, Day, Year)		al.	29b. Signature and title of certifier	Σ	To t To t	
	D0025759 February 16, 2004			· Willest			
waiter K. Naumann, M.D., 10 Box 247, Accident Fib 21520	Accident MD 21520						
State Registrar  31. Date filed (Month, Day, Year)  FEB 17  32. Registrar Signature  2001  Appendix	food	w & Sports	32. Registrar Signat  1. 7 200				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 20, EDNA MAE CIARAVELLA 2004 12:50 A<sup>M</sup> /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F 77 234-36-6941 PENNSYLVANIA Director JAN. 21, 1927 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28a-f ehow Exempler must be notified at 1 ☐ Yes 2 No Directo QUEEN ANNE'S **STEVENSVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 21666 131 ALLEGANY ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 [] Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status pernit. Pages 1 and 2 should be tiled within 72 hours after d Deportment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Iten any njury or other traumatic event, the Meulial Erath at Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ARVANA HANLIN GEORGE L. FELIX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK CIARAVELLA/ HUSBAND 609 GLENVIEW AVE., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) CHESAPEAKE CREMATORY \* 4 Donation 02/23/2004 STEVENSVILLE, MD 21. Signature of Fundral Service Licensee lame and Address of Facility
LOWS HELFENBEIN & NEWNAM FUNERAL
SHAMROCK RD., CHESTER, MD 21619 HOME, P.A. at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 4 Pregnant at time of death the 9 Unknown 9 Unknown been signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate rema 1 Yes 2 No 2 No 1 Tyes Hospital or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 3 1 Stime lient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 ⊟Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a 1 Properties of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ane) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Z-20°C 1401 30. Name and ad has 1 p rean who completed cause of death (Item 23a) (Type, Print) GREGORY A. MITCHELL M.D., 2001 MEDICAL PARKWAY, ANNAPOLIS, MD 31. Date filed (Month, Pay Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

B.K.S	
TUTUTUOV	Т:

JEFFERY LEE CAMERON Item#1 Amend Item#1 State of Maryland / Department of Health and Mental Hygiene For Unpend Item#23a,27,PerME.G830,4/2/04e8ertificate of Death Reg. No.

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Reg. No.	6	U	UH	U	1	08	
rrygiche	2	0	01	^		^ ~	

Physician
/Medical
Examiner
Funeral
Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ral, or items 23a or 28a-f show Examiner must be notilized at "natural", or Items 23a permit. Page Department of Important: If eny injury or once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

> as the burial-tran. the attending physician and esn ğ detached ģ signed **P** peeu has this filled in by the funeral After death.

The law requires that the death certificate be executed

or Attending Physician:

Director

within 24 hours a

To the

Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year 1400 P M Jeffrey MARCH 2,\_ 2004 Cameron 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 1 X M 2 ☐ F 35 220-06-8397 02/09/1969 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 Yes 2 No Cumberland Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13005 Bedford Road, N.E. 21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕍 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-employed Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cameron Robert Janet Lee Hartung ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Cameron / brother HC 86 Box 610, Greenspring, WV 26722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 03/04/2004 Cumberland, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that registed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat Atherosclerotic Cardiovascular Disease resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequance of): Examiner resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medical examiner?

YXYes 2 \( \text{No} \) Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ٩ 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E MARCH 3, 2004 MD who completed cause of death (Item 23a) (Type, Print)

State Registrar

lasha L 31. Date filed (Month, Day, Year)

22. Registrar's Signature

-Over user a

2004

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryland /	Department of F			ene a. No.2 0 0 4	07090
	بمثني		Decedent's Name (First, Middle, Last)	)	Continuate or	Death	2. Date of Death	_	3. Time of Death
	Physici /Medi		EdNa/	M. Davis			Month OZ	Day Yeer 17 04	550 AM
	Examir	er	4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, o	Location of Deat	h	4c. County of Deet	Sec.
	Funeral		5. Social Security Number 6. Sec	x / 7. Age (In yrs. last b	irthday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth		11CO
Ē.	Director		2/5-28-93/2 10	M 20 F 76	Yrs. Months Days	Hours Min.	(Month, Dey, Y	'eer) Co	untry)
	and *		Usuel Residence of Decedent  10a. State 10b. County	10c City To	vn or Location	<u>'</u>			
	Marylan f ahow	5	DE New Ca		minaton				10d. Inside City Limits 127Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	3118	10f. Zip Code		10g	g. Citizen of What Co	untry?
	th with	a D	421 Allens Aly		1980	) (		U.S. A	
	or dea	Funeral	11. Marital Status	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> </ol>	13. Was Decedent of H II Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: Q	10 - 12
9-0	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow he Madical Examiner Larat Le ricitilled at	ted	15. Decedent's Edu	cation 16a	Decedent's Usual Occup	ation	16	ib. Kind of Business/i	industry
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ary	2 should be and Mental is marked o	-	19a. Informant's Name/Relationship (Ty		b. Mailing Address (Street a				
Σ,	and 2 ealth a m 27 is		Lisa Hines - Dau	ighter 4.	of Disposition (Name of	A1-101	Imington	0- 1980	ò i
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-1 ahov amy injury or other traumatic event, the Medical Examiner hast be routilled at ODEs.		20a. Method of Disposition  18 Burial 2 Gregnation 3 GR	lemoval from State	ny, cromatory or ouror plac	Θ)			
턡	ritmer ritmer ritent: njury	1	<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of uneral Service License</li> </ul>	p unio	22. Name and Address	Cem! 2/	18/04 C	ecitton, 1	1d
Ba	permit. Departr Imports any inj		, seel	- 1-	917. W. ISA	Lelle CL S	Lib on	HA FUNEN	1 Home
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do	not enter the mode of dying	g, such as cardiac	or respiratory arrest	ma sie	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence		11112			
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events						
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Вох	es that the death certific igned by the attending p be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	3c. Il yes, outcome of pregnancy				23d. Date of deliv	1001
m m	death e atte	icla	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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Division of Vital Records,	signed d be d	þ	Part II. Other significant conditions con		n the underlying cause give	en in Part I.		co use contribute to t	the cause of death2 bably 4 Unknown
COL	w requir been s should	letec	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				· · · · · · · · · · · · · · · · · · ·		
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<u> </u>		BeC	25. Was case referred to medical examiner?			26. Place of Deal	1 ☐ Yes 2 ☑ th (Check only one)	YNo 1 ☐ Yes	2□ No
> 5	Attending Physician: The la r death. cotor: After this certificate has by the funeral director, page 2	P.	1 ☐ Yes 212 No	ospital: 1 Inpatient 2 ER/Ou		4 UM Nursing Ho	ome 5 Residence	e 6 □Other (Speci	fy)
uo Ou	ding P	:io	27. Manner of Death  1 Anatural 5 Pending 2 Accident Investigation		Time of 28c. Injury Nork  M 1 □ Y	at ? /es 2 □ No	28d. Describe how in	njury occurred	
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ā	tal or A	Certification:	4 Homicide determined	building, etc. (Specify)			City or Town, S.	tate)	
	To the Hospital or within 24 hours afte within 24 hours afte completely filled in the	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	a, death occurred at the timed/or investigation, in my op	e, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Month,	Day, Year)
			Solvan, 1	1. D.	057	1953	-	2/18/2	004
			30. Name and address of person who co Babulal Das, M.	mpleted cause of death (Item 23a)  D. 106 Milfor					
İ	Sta Registra		31. Date liled (Month, Day, Year) FEB 2 0 20	32. Registrar's Signature	& Spark				•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician reb. 1 22, 2004 9:10 AM /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 17€M 2□F Months Days Hours Min. 213-24-078
Usual Residence of Deceden Yrs. Director permit. Peges 1 end 2 should be filed within 72 hours efter death with the Menyland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, I'm Medical Examinar mass in a continued. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** COMICO LISBURL 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2180 200 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ∑Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Dives 2 Kyes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Completed by BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced ARMI Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) EANING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVIS KE 5516 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENNETT - DAKENTER 28317 - ADK NS position (Name of SHEILA SAL Seur y MD 2150 20c. Location - City or Town, State 2130 20a. Method of Disposition Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) VA 3 HURLOC 1/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BENNIE LISABELLA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Q C Examine Due to (or as a copsequence of): Physician/Medical Examiner 0 attending physician and I for use es the bunel-trensit or Attanding Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated asserts or injury) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of): ate hes been signed by the a pege 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Tyes 2 PNo 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 2 No Other: ٩ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funerel 27. Mann Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of edical Certification: 28d. Describe how injury occurred 1 Naturel 5 Pending within 24 hours efter deeth.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) illiam M.D 1346 S. Division St. Suite, Salisbury, Md. 21804 31. Date filed (Month, Par Year) 4 2004 32. Registrer's Signature State Registrar rocks

State of Maryland / Department of Health and Mental Hygiene For State Registrar 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day JAMES ERWIN DOOLEY FEBRUARY 23, 2004 8:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. B. Date of Birth (Month, Day, Year DEC. 3, 1 QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1**X**M 2□ F Director 408-14-4928 84 1919 TENNESSEE Usual Residence of Decedent Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 961 CLOVERFIELD DRIVE 21666 Herns 23a USA Funeral death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 Never Married 2 Married 1 **X** Yes 2 □ No If Yes, Give Year or Dates: 0 Baltimore, Maryland 21215-0036 tby. 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced natural', Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 **ENGINEER** CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I T. FLOYD DOOLEY EDNA MCQUIDDY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 ts eny injury or other training once. ANNABELLE DOOLEY/WIFE 961 CLOVERFIELD DR., STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State ຳ 4 Donation 5 Dother (Specify) ALL SAINTS CEMETERY 02/27/2004 REISTERSTOWN, MD 21. Signiture Fun-val ervice Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 Part 1. Enter the disease, or complication in hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one if up a on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiany or all **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dira to (or se a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be d Completed by 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the f Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or to the Funerel Direct completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 6 29b. Signature and title o cerulier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

			For State Registrar	State of Maryland	/ Depa		lealth and M	lental Hyg	_	
ī	Physici /Medic		1. Decedent's Name (First, Middle, Las Lilliam Fi	995				2. Date of Death Month Feb	Day Yea	3. Time of Death
	Examin	ner	4a. Fecility Name (If not institution, give	l Hospital C.	enter	Salisi	Location of Death		Wicem.	,60
	Funeral Director		5. Social Security Number 6. Security Number 214-32-0817  Usual Residence of Decedent	7. Age (In yrs. Ia.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1-4-191	9. B	inthplece (State or Foreign Country) Md.
breing Manufacture	f show	tor	10a. State 10b. County  Md. Worcest		Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
the state of the s	s or 28a. De notif	Director	10e. Street and Number		iow iii	10f. Zip Code			0g. Citizen of What	Country?
	, or Iteme 23	by Funeral	217 S. Washingto:  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			863  Iispanic Origin? (Spean, Mexican, Puerto  Specify:		Specify:	
ILIS-UUSO	n netural	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced (Give life. I	dent's Usual Occup kind of work done DO NOT use retire	pation during most of works d)	ng	16b. Kind of Busines	White s/Industry
V 5	Hygiene. other than	e Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	В	us driv	er 18. Mother's Name		School Maiden Sumame)	
yland yland	Mental Parked c	To B	Glen Evans				Ethel W			
nore, mar	heard year transfer of the memory in the memory is a second transfer of the memory is		George L. Figgs,  20a. Method of Disposition  ABurial 2 Cremation 3 Company  4 Donation 5 Other (Specific	Son 20b. Pla	100 ce of Dispo netery, cren	ng Address (Street Powell S sition (Name of natory or other place orial Cer	Snow	Hill, M	City or Town, State  d. 21863 20c. Location - City of Snow Hil	or Town, State
Dallumor	Department Important: If any njury or once		21. Signature of Funeral Service Licen		22 S	2. Name and Addre	ss of Facility	1.000	SHOW HII	I, rid.
bo executed	hysician //Medical xaminer	dicai Examiner	23a. Part1. Enter the disease, or computed to the shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  C. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	Do not ent	er the mode of dyir			ost,	Approximate Interval Between Onset and Death  A Week  Several year
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TOS, T	been signed by the should be detached	by	Part II. Other significant conditions of	2 1/	ting in the u	nderlying cause give	ren in Part I.			lo the cause of death?  Probably 4 \(\overline{\pi}\) Unknown
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	1 e e		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	Wo	y at rk? Yes 2 □ No	28d. Describe ho	w injury occurred	
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1	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical		ysician: To the best of my know niner: On the basis of examination and manner stated.						
,	A P	Σ	29b. Signature and title of certifier	hp.	m)	29c. Licens	16003		2/18/0	nth, Day, Year)
_	) (V. 1		Irija Hwan		PO	BOX 20	olf, Sali	sbury	MD 2	1802
N	Sta	ate	31. Date filed (Mente By, Year) 2	32. Registrar's Signatu	ire $\mathcal{G}$	Spark	1	*		

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		_	Registrar		Certifica	ite of Deat		Reg. 2. Date of Death	No. C U		1093
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	/Medi Examir	cal	Consuella Bernice Bo 4a. Facility Name (If not institution, give street			y, Town, or Locatio		ebruary	14 20 4c. County of I	104	31/ M
			Atlantic General Hos	pital		Berlin			Worce	ester	
l i	Funeral		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last	Month:	er 1 Year If Und	er 24 Hrs. 8	Date of Birth (Month, Day, Ye Sept. 30,	ar) 9.	Birthplace (Sta Country)	te or Foreign
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~	pur *		Usuel Residence of Decedent  10a. State 10b. County	10c. City T	own or Location					10d Insid	e City Limits
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00	the N	ect	Maryland Worcester  10e. Street and Number	Berl		ip Code		100	Citizen of Wha	t Country?	
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100	atter death with the Maryland or Items 23a or 28e-f show or Items 25 or 28e-f show or items he redified at	Funeral Director	408 Flower Street  11. Marital Status 12. W	Vas Decedent Ever in U.S.	13. Was Dec	21811 edent of Hispanic 0	Origin? (Speci	fv Yes or No-	USA 14. Race -	American Indian	١.
	ō ≟ ≝	돌	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. .rmed Forces? ☐ Yes 2X No	1	edent of Hispanic C ecify Cuban, Mexic		can, etc.)	Black, \	White, etc.	
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25			19a. Informant's Name/Relationship (Type, F	1	100	ss (Street and Num				te, Zip Code)	
6			Louis Bowen/son	20h Plan	3890 Pont	tevedra P	lace -			1349	
7	3 5 5 5		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remove	varirom State	e of Disposition (Netery, crematory or	1				y or Town, State	'
9/30/10	permit. Pag Department Important: I any injury o		`4 □Donation 5 □ Other (Specify)	St.		ch Cem.					
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5-			23a. Part1. Enter the disease, or complicatio shock, or heart failure. List only one ca	use in chiline.	Do not enter the mi	ardious Diaba	as cardiac or i	respiratory arrest,		Approxii Interval Onset a	Between nd Death
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66	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Directors of fury that initiated events c	(0						Į.	
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3;	r.C. DOX or requires that the death certifica een signed by the attending ph nould be detached for use as it	by Physician/Med	Part II. Other significant conditions contribu	ting to death but not resulting	ng in the underlying	cause given in Par	rt I.	23e. Did tobacc	o use contribu	te to the cause	of death?
⇒ ₹	v require							1 Tes	2 No 3	Probably	Unknown
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3	The I te ha	E						autopsy performed 1 Yes 2	?deat	rto completion o h? Yes 2□ No	or cause or
)		Be C	25. Was case referred to medical			26. Pla	ice of Death (	Check only one)			
末:	- S S	To	examiner? 1 Yes No Hospit	tal: 1 ☐ Inpatient BER	/Outpatient 3 🗆	OOA Other: 4	Nursing Home	5 🗆 Residence	6 □Other (	Specify)	
26	ng Ph ter thi		27. Manner of Death  1/SAlatural 5 □ Pending	Ba. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury at Work?	28	d. Describe how in	jury occurred		
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	5 4 1 9 8 4 2 9	Medical	(Check only 2 Medical Examinar: (	n: To the best of my knowle On the basis of examination	dge, death occurre and/or investigation	d at the time, date a	and place, and eath occurred	d due to the cause at the time, date a	(s) and manne and place, and	r as stated. due to the caus	ie(s)
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			1 1 Value	ted sauce of death /lea- co	(Type Briet)	1000	ace to	Hu	ture		
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WYG	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4	na Va	( 7 /	7			
	Regist		FEB 1 9 2004	Depera	P 19	vous v					

				1 - For State Registrar			d / Depa		Health and Note to Death	Mental Hy	_		77091
				Decedent's Name (First, Middle, Last	)					2. Date of De.	ath	3	. Time of Death
		Physic /Medi		Marion L. Foxwel						Felsey	Day 15	Year 2004	1/02 M
1		Exami	ner	4a Facility Name (If not institution, give	street and number,	. 1	103	4b. City, Town, o	or Location of Death		4c. Count		
			7	5. Social Security Number 6. Se			ast birthday)	If Under 1 Year	Source Hrs.	R Date of Birth	Wil	Comicu	
	ŀ.	Funeral Director			бм 2□ F 7		Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 6-23-1	y, Year) 931	Country)	DE.
		yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10d.	Inside City Limits
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		with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?	
		eath v	era	34679 Gordy Road	12 Was Dacadast	Suprin III	6 12 1		956		USA		- 42-
	36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at sons.	by Funeral I	11. Marital Status  1 □ Never Married 2 → Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1∑Yes 2☐ If Yes, Give Year or Dates:	No 195	0-   .	Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	Bla Specif	ce - American II ck, White, etc. Y: Whit	
	Maryland 21215-0036	72 hou	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	lent's Usual Occup	pation during most of work	ina	16b. Kind of B	usiness/Industr	
	121	within ne. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of work	9	D - 0+	- h - D - 1	4
1	9	filed v Hygie ther I		12 17. Father's Name (First, Middle, Last)			Traii	ic Lieut	18. Mother's Name	a (First Middle		ate Pol	ice
77	an	ld be ental ked o	To Be	Harry M. Foxwell					Louise			1187	
5xwe	ary	shou and M mar	-	19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street	and Number or Run			State, Zip Coo	de)
X		and 2 salth a 127 ls		Louise P. Foxwell,	Wife				Rd. Laur				
10	Baltimore,	of He		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Pi	ace of Dispos	sition (Name of natory or other place	ce)	Date	20c. Location	City or Town,	State
	Ë	Pag tment tant: jury c		*4 ☐Donation 5 ☐ Other (Specify)		Spr			Gardens		Hebr	on, Md.	
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3				23a. Part1. Enley the disease, or compleshock, or heart failure. List only of	ical ons that cause	d the death	. Do not ente	or the mode of dying	ve St. De ng, such as cardiac d	or respiratory ar	e . 1994 rest,		proximate erval Between
E		Physician		Immediate Cause (Final disease or condition				2L Ble				Ons	set and Death
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	89	rtificat ng phy as th									THE STATE OF THE S		
	P.O. Box	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1		23d. Dai Mo	e of delivery nth Day	Year
	9.	ires that the d signed by the d be detached		Part II. Other significant conditions cor	ntributing to death b	out not resu	ltina in the un	deriving cause give	en in Part I	23e. Did to	bacco use cont	ribute to the ca	use of death?
	ds	luires n sign ald be	d by						J		es 2□No	3 ☐ Probably	
	000	aw requ s been s should	Completed							24a. Was a	an 24b. \	Vere autopsy f	indings available
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	ita	ysician: The is certificate ha director, page	Be C	25. Was case referred to medical					26. Place of Death	1 Yes		□Yes 2□	NO
	× ×	hysic his ce	안	examiner? 1 Yes 2 No	lospital:		R/Outpatient	3□ DOA Oth	er: 4 🗆 Nursing Hor	ne 5 ☐ Reside	ence 6 Oth	er (Specify)	
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	Divi	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical Chemister of the Funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, stre	et, factory, office		28f. Location (Si City or Town		er or Rural Rou	ute Number,
		he Hosp in 24 hou he Funer pletely filt	edical	29a. Certifier 1 Certifying Physical Examinations 2 Medical Examinations	sician: To the best ter: On the basis o and manner st	f examinati	riedge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cand at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the	cause(s)
		To within	Me	29b. Signature and title of certifier				29c. License		2	9d. Date signed	(Month, Day,	Year)
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		TIVE		30. N me and address of person who co	7 305	Ter	voh .	rint) Po	aco moll.	e City	Mo	2 180	1
	130	Sta		31. Date filed (Month PEB at 9 2	004 32. Registr	ar's Signatu	119 G	Span	6				

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	Physici	an	Decedent's Name (First, Middle, Last     ALBERT ARNOL							2. Date of Month Februa		200 <sup>Year</sup>	3. Time of Death 1705 M	ı
	/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City,		Location of	of Death		unty of Deat	th	
			Memorial				lf Lindon		Casto		2:4	Talbo		
	Funeral Director		5. Social Security Number 6. St 212–40–9142	MA OFF	Age (In yrs. 61	last birthday) Yrs.	If Under Months	Days	If Under	Min. 8. Date of (Month, APR . 1)	$D_{ay, Year}$	9. Birt Co MAR	hplace (State or Foreigr buntry) RYLAND	1
	D		Usual Residence of Decedent		40- 0								10d. Inside City Limits	_
	72 hours after death with the Maryland natural; or Items 23e or 28e-f show iteal Examirer must be mulffied ut	ŏ	10a. State 10b. County  MD TALBOT			ty, Town or Lo		5					1 ☐ Yes 2X No	
	r 28a-1	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Citizer	n of What Co	ountry?	_
	23e o	alD	109 MILES LANE	, APT.	120		21	1663			US.	A		
	er dea	uner	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Deced If Yes, spec	lent of Hi	spanic Ori n, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No- 14.	Race - Ame Black, White		
36	urs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 [ If Yes, Give Year or Date			1 ☐ Yes	2 <b>▼</b> No	Specify:		Sp	ecify: W	HITE	
21215-0036	72 hou natura	ted	15. Decedent's Ec	lucation de completed)		16a. Dece	dent's Usua	I Occupa	ition	t of working	16b. Kind	of Business/	Industry	
121	within lene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	TUGBO	DO NOT us	se retired,	)	•	MARTN	F CONS	TRUCTION	
d 2	filed withi Hygiene. other than		12 17. Father's Name (First, Middle, Last)	-0-		LUGBC	AI G	A IVI		r's Name (First, Mid			TROOTTON	
au	ould be Mental tarked o	To Be	GEORGE HARRY GOL	T, SR.						LILLIAN A	. ROE			
Baltimore, Maryland	and and ls m		19a. Informant's Name/Relationship ( ZOE MARTINA FERR		TER					or or Rural Route Nu.				
e,	ges 1 and 2 t of Health If item 27 or other tro	1 3	20a. Method of Disposition	10	20b. F	 Place of Dispo cemetery, crei	sition (Nan	ne of ther place	9)_	Date		tion - City or		
<u>E</u>	Page ment c ant: If ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		CENT	SAPEAKI FFR, LI	E CREN LC	1ATI(	ON	2-20-2004	STEVE	NSVILI	E, MD	
Balt	permit. Pages 1 Deportment of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licer	Mary Contract of the Contract		FI FI	LLLOWS	S, HEI	LFENB	EIN & NEWI	NAM FUN REVILLE	ERAL H	IOME, P.A. 21617	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	on sause on each	sed the deat h line. UV as a cons	g Ca	nec	e of dying  Lov	g, such as	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death 27-ears	<u></u>
8760,	rate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any lauding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consec									
P.O. Box 6	ne death certific the attending p thed for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnan 9 Unknown	n 2∐Feta tattime of o	aldeath 3	Ectopic pr				230	I. Date of del	ivery Day Year	
	uires that the signed by ald be detacted	Ď.	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the u	1 1	ause give			id tobacco use		the cause of death?	1
of Vital Records,	sicien: The law requir s certificate has been si lirector, page 2 should	Completed	Head and	kech	Can	eo.				24a. W	itopsy erformed?	prior to death?	itopsy findings available completion of cause of	•
ital	ien: artifica ctor, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death (Check on				_
of ∨	Physic this ce al dire	မှ	1 ☐ Yes 2 ☐ Nø	Hospital: 1 ☐ Inp		ER/Outpaties		-	4 🗆 140	rsing Home 5 R			cify)	_
UC C	ding F n. After funera	tlon:	27. Manner Death  1	28a. Date of I (Month,	Day Year)	28b. Time o Injury	M Z	8c. Injury Work	rat :? /es 2 □ I		be how injury o	ccurred		
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	Injury - At h , etc. (Speci	ome, farm, st fy)	reet, factory	r, office			n (Street and N Town, State)	lumber or Ru	ural Route Number,	_
_	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Medical Ce			s of examina					d place, and due to t th occurred at the tin				
	ro the	Me	29b. Signature and title of certifier				290	. License	number		29d. Date s	igned (Monti	h, Day, Year)	
	->-0		> Misilies	- DE			1	1428	587		02/	20/2	004	
			30. Name and address of person who RVSSCU # SChil	completed cause	of death (Ite	m 23a) (Type,	Print)	od D	rive	Easton	md z	1601		
	Sta Regist		31. Date filed (Month, Pay Year)2	2004 <sup>32. Reg</sup>	istrar's Sign	ature	Span	K				*		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Bradley Thomas HARVEY February 13 2004 10 15 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3080 Pysell Crosscut Road Oak land Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 1 ★M 2 1 F Yrs. Director 215--10--5615 97 Feb. 16. 1906 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Show rthan "natural", or Items 23a or 28e-f shov the Madical Experimer must be nutified at 1 ☐ Yes 2X No Director MD Garrett 0akland 10e, Street and Number 10g. Citizen of What Country? 10f. Zin Code 3723 Garrett Road 21550 USA death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) 6th Coal Mining Coal Miner permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event side. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harvey Adella Jane Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley J. Harvey/son 3080 Pysell Crosscut Road, Oakland, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2/14/2004 Morgantown WV \* 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory 22. Name and Address of Facility 21. Signature of Fune a Service Licensee Stewart Funeral Home 32 S. Second St Oakland, Md. 21550 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CVA- Left Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CHF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? COPD autopsy performed? 1 Yes 2 No certificate 2 □ No Pneumonoconiosis 1 Tes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Nother (Special Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? erel Director: After th illed in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H26154 February 13, 2004 Dames 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. 69 Wolf Acres Drive Oakland Md. 21550 P. Daniel Miller 31. Date filed (Month, Pay, Year) FEB 1 8 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2004

			1 - For State Registrar	State of Maryla		ent of Health and ate of Death	d Mental Hygie	2004	07098
	Physic		1. Decedent's Name (First, Middle, La	st)	JACKSO		2. Date of Death Month	Day Year / 3 2004	3. Time of Death
	/Med Exami		4a. Fecility Name (If not institution, giv	re street and number)		ity, Town, or Location of De		4c. County of Death	1
	LABITIT	ilei	Peninsula Regio.	NOI Medical	Penter	SAUSBUM		Nicon	4
1	Funeral Director		5. Social Security Number 6. S 215-62-0462 Usual Residence of Decedent	Sex 7. Age (In yr.	7 Yrs. If Un	nder 1 Year If Under 24 H hs Days Hours M	Irs. 8. Date of Birth (Month, Dey, Ye	ear) 9. Birth	nplace (State or Foreign untry)
1	land ow		10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
1/2	Many a-f sh	ģ	MD Wicon	ni'ca S	Salisbu	ru			1 Yes 2 No
0	death with the Maryland me 23a or 28a-f show Listed by notified at	Funeral Director	10e. Street and Number		10f.	Zip Code	10g.	. Citizen of What Cou	intry?
U	death w	era	5 772 Cork St 11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was De	ecedent of Hispanic Origin? Specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ameri	ican Indian,
6	ē = =	y Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		specify Cuban, Mexican, Pu s 2 <b>D</b> No <i>Specify:</i>	erto Rican, etc.)	Black, White	, etc.
N	15-0036 72 hours after "natural", or te	ed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E	Year or Dates:	16a. Decedent's U		161	b. Kind of Business/Ir	ACK
	Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mantal Hyghene. 27 is marked other than "natural", or traumatic event, the Madical Exert.	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give kind of	work done during most of v T use retired)	vorking	). Kind of businessin	ioustry
de	d 2121 filed within Hygiene. wither than and, the Men	Com	12	5+	0 1510	le Secreter	YH	EAHA L	2p. It ment
13	land lite of lite of the country land land lite of land land land land land land land land	Be	17. Father's Name (First, Middle, Last,	( ) a		A .	lame (First, Middle, Mai	den Sumame)	
R	larylar 2 should by and Menta is marked aumatic e	2	19a. Informant's Name/Relationship (	Ceak Type, Print)	19b. Mailing Addr	ress (Street and Number of		DY) acce	A Code)
,,			-31-1 1	on-Dille hter	15772	73.7	ishery, med		3 3000)
1/1			20a. Method of Disposition	20b.	Place of Disposition (I	Name of		c. Location - City or T	own, State
100	Baltimore, permit. Pages 1 ar Department of Head Department of Head Department: If item any injury or other page.		^4 □ Donation )5 □ Other (Specif	y) Gr	een Acres	Cometary 2	121/04 S	klisbury.	md
J. H.	Baltimo permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	nsee	2.00	and Address of Facility (	0.1	the French	21801
O	<b>36</b>		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the decone cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Septu	Shire	A		<b>x</b>	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		2	1	1
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):	-110 marc	gelo- con	galisas	Hrens
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Prema	manca				days
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	68760, ifficate be ex g physician as the burial	dicai	•	d. conger	1cm	read fry	Par		mesells.
	Box 68 death certifica settlending phy of for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of delive	erv
	I Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown		c pregnancy (specify)		Month	Day Year
	P.O.	Phy	9 ☐ Unknown  Part II. Other significent conditions of	contributing to death but not re	esulting in the underlyin	g cause given in Part I	23e. Did tobacc	co use contribute to the	he cause of death?
	Cords, P.O.  M requires that the de been signed by the should be detached	d by	agreed C	ances		3			bably 4 Unknown
	aw rec	Completed		•			24a. Was an	24b. Were auto	opsy findings available impletion of cause of
	The I	Com					autopsy performed 1 ☐ Yes 2 €	death?	
	Vita ician: sertific ector.	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)		
	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	☐ ER/Outpatient 3☐ 28b. Time of		Home 5 Residence		у)
	ion nding ith. r: Afte e fune	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	233. 2333133 1134 11	ijary occurred	
	Division of Vital Records, to Attending Physician: The law requires that endeath. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, fact	tory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	Division of Vital Rec To the Hoepital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	nowledge, death occurr	ed at the time, date and pla-	ce, and due to the cause	e(s) and manner as s	tated.
	the Ho in 24 the Fu	Medical	(Check only 2   Medical Exert	niner: On the basis of examin and manner stated.	nation and/or investigati	ion, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
	To To	2	29b. Signature and title of certifier	2/1/		29c. License number	29d.	Date signed (Month,	Dey, Year)
	7		30. Name and address of person who	completed cause of death (Ite	ım 23a) (Tyne Print)	11/1/	19	14/04	
			William Kobin	M.O. 11	04 HEALT	WHAY Dr.	SACISTURY	100	
	St. Regist	ate a	31. Date filed (Month, Day, Year) FEB 1 8 2	32. Registrar's Sign	pature &	books			

State of Maryland / Department of Health and Mental Hygiene 2004 07099 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Febuary 10, 2004 **Physician** 2031P. M Larry W. Johnson, Jr. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2□F Months 31 May 2, 217-96-2672 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Example must be notified at 1 X Yes 2 □ No MD Worcester Berlin Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Jefferson St. 21811 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygien 7 is marked other th Warehouse Worker Retail 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Larry W. Johnson, Sr. |Margaret Ann Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n sny injury or other traun once. Selbyville, DE 19975 Margaret Dickerson/mother P. O. Box 828, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Curtis UMC Cemetery 2/20/2004 4 ☐ Donation 5 ☐ Other (Specify) Bishopville, MD Lientine 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MULTIPLE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year jo 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 99 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1⊠ Yes 2 🗆 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 - ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Certification: To his 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? DRIVER OF MAR COLLIDED WITH 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑No 2110/04 PM 7:47 death. OTHER VEHILLE 2 Accident hours after deal 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by determined 4 Homicide within 24 hours after To the Funeral Direcompletely filled in by Hospital or ROAD RT 113 & GERMANTOWN RD. M.D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Wied Febuary 11, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MO RNB10, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 8 2004 Registrar

	1	For State Registrar	State of Maryle	Ce	artment of Heartificate of De	eath	R	eg. No. 2	004	0710
Physicia /Medic	an	Decedent's Name (First, Middle, Last     DAVID		ERR			2. Date of Dear Month FEBRUAR	Day	Year 2004	3. Time of Death 4:08P.
Examin	er	4a. Facility Name (If not institution, give 301 TACKLE CIRCLE			4b. City, Town, or Lo			QUEE	nty of Death	
Funeral Director		002-30-3034	ex 7. Age (In y	rrs. last birthday Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV - 4,	949	NEW Y	ORK
show ad at		Usual Residence of Decedent  10a. State 10b. County  MD QUEEN		City, Town or L					10	0d. Inside City Limit
or 28a-f	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o		try?
23a c	rai	C DOCK, CASTLE HA	· · · · · · · · · · · · · · · · · · ·	110	21619			US	A ace - Americ	an Indian
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th and Me	<b>1</b>	19a. Informant's Name/Relationship (	Type, Print)		ing Address (Street and					Code)
rages I ario nent of Health int: If item 27 I iry or other tra		20a. Method of Disposition  1 Burial 2 ACremation 3 4 Donation 5 Other (Specif	Removal from State CH	cemetery, cre IESAPEAK	osition (Name of ematory or other place) E CREMATIO	ı	1	20c. Location		
Department of Important: If i any injury or once.		21. Signature of Funeral Service Lies		ENTER, I	LC 22. Name and Address ELLOWS, HELD 08. S. LIBE	of Facility FENBEIN RTY ST.,	& NEWNAI CENTRE	M FUNE	RAL HO MD 21	ME. P.A. 1617
nysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that crused the cone cause on the line.  a.  Due to (or as a cone	sters	iter the mode of dying,	such as cardiac o	er respiratory r	est,	86	Approximate Interval Between Onset and Death
realiticate be executed that the purish-transit and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sue to (or as a con  Due to (or as a con  d.						555	
e atter	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 I 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				Date of delive Month	ny Day Year
p eg		Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause given	in Part I.		bacco use co es 2□No	A .c	ie cause of death? abiy 4 □Unkno
ate has b	Completed						24a. Was a autop: perfor Yes	SV	prior to cor	psy findings availantle poletion of cause 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death				
rhis raldi	. To	Yes 2 No 27. Mannar of Death	1 Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	SIT 3 DOA	4   Nursing Ho	me 5 □ Resid 28d. Describe h			SCENE
r Attending Ph er death. rector: After th by the funeral	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to 4 Homicide	on De Place of Injury	At home, farm, s	M 1 Ye	s 2 🗆 No	28f. Location (S City or Tow	treet and Nui n, State)	mber or Rura	l Route Number,
within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Cer		hysician: To the best of my miner: On the basis of exar and manner stated.							
To the within 2 To the Comple	Med	29b. Signature and title of certifier	and marinor states.		29c. License r	number	2	9d. Date sig	ned (Month,	Day, Year)
_ < L ~	1	.//////////////////////////////////////	111							

DHMH 17 Rev 1/2001

**ORIGINAL** 

CI	17		For State Registrar	State o	f Maryland	/ Depa	rtment of H tificate of L	ealth and Death	Mental Hy	giene Reg. No	2004	071	01
Š	Physici /Medic		1. Decedent's Name (First, Middle LINDA GREER K	· ·					2. Date of De Month Februa:	Day	y Year 5, 2004	3. Time of De 12:51	P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, 170 Mt. Ararat	Farm Roa	ad		4b. City, Town, or Port De				Cecil		
	Funeral Director		5. Social Security Number  172-42-1133  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. las 49	Yrs.	Months Days	Hours Min.		ay, Year)	Phi.	place (State or Fintry) a. PA	oreign 
	the Maryland r 28a-f show	Director	10a. State         10b. County           MD         Ceci.           10e. Street and Number	L		Town or Lo				10g. Cit	izen of What Cou	10d. Inside City L	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23s or 28s-1 show aumatic event, It's Medical Examination and building at	by Funeral D	170 Mt. Arara	12. Was Dece Armed Fo	edent Ever in U.S. prces? 20 No	,	21904 Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		SA  14. Race - Amer Black, White  Specify: Wh	, etc.	
21215-0036	d within 72 hour jiene. ir than "natural ire Moulcal E	Completed t	(Specify only highest Elementary/Secondary (0-12)	s Education		(Give lite. l	lent's Usual Occupa kind of work done of OO NOT use retired	furina most of wo	rking	16b. K	ind of Business/li	ndustry	
Maryland 2	should be filed nd Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, I	,		- O II Gill	J. Oy Cu		me <i>(First, Middle</i> Heimann	, Maiden	Sumame)		
Mar	es 1 and 2 should by Health and Ment litem 27 is marked rother traumatic e	•	19a. Informant's Name/Relationsh Patricia G. Si		Sister	103	g Address (Street a Lampeter		ncaster	, PA	17602		
altimore,	Pages 1, ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State cerr	netery, cren	sition (Name of natory or other place Memorial	1	Date 3/1/04		ocation - City or T		
Balt	permit. Page Department. Important: It any injury o		21. Signature of Funeral Service I	Bute	ez.		Name and Addres	range St	.,Lanca	ster	ff, Inc. ,PA 1760	3	
	Pnysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	aus the death. each line (or as a conseque	sel	er the mode of dying	g, such as cardia	or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea	
87604	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Lus to	or as a conseque	noa of):							
O. Box 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown	1☐Live b	icome of pregnanc birth 2  Fetal di nant at time of deal own	eath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Yea	r
0	n requires that to been signed by should be detail	by	Part II. Other significant condition	ns contributing to de	eath but not resulti	ng in the u	nderlying cause give	on in Part I.	23e. Did t		use contribute to	the cause of deat	
Il Records,		Completed							24a. Was auto perfo		prior to co	opsy findings ava ompletion of caus 2 No	ilable e of
on of Vital	iding Physician: The th. Ster this certificate funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Autural 5 Pendin investig	28a. Date (Mon.	Inpatient 2 EF of Injury th, Day Year)	VOutpatien 8b. Time of Injury	28c. Injury Work	ar: 4 \sum Nursing F	ath (Check only of Home 5 - Resi 28d. Describe	dence	6 Other (Specially occurred	<sub>fy)</sub> at sce	ne
Division	al or Attending s after death. if Director: After id in by the fune	Certification:	3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Rui i)	al Route Number	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical (	29a. Certifier 1 Certifyin 2 Medical	g Physician: To the Examiner: On the b and man	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the time restigation, in my op	ie, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as a d place, and due t	stated. to the cause(s)	
)	To the vithin 2 To the complet	M	29b. Signature and title of certifier	Lem	W)	20) 77:		onumber O.C.M.E.			te signed (Month, Tuary 26		
- 4	Sta	ate	31. Date filed (Month, Day, Year)	10000 32. F	se of death (Item 2 degistrar's Signatur	11	1 Penn St	treet, B	altimore	e, Má	aryland (	21201	Į.
	Regist	rar	MAR 9	9 2004	STATE OF THE PARTY	A. S.	122125	-					

O -			
Mar	cellus	T.	Maddox
			Ear

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	State of Maryland	Certificate of		Reg. No.	2004	07   02
Physic /Med Exam	ical	Decedent's Name (First, Middle, Last)     MGY Cell US     4a. Facility Name (If not institution, give s	MA dd	4b. City, Town,	or Location of Death	February 1	5 2004 County of Death	0049a <sup>M</sup>
Funera Directo		Peninsula Region  5. Social Security Number  2/8-17-8317			r If Under 24 Hrs.	8. Date of Birth (Month, Day, Year 1 - 29 - 8	Coun	lace (State or Foreign try)
and w.		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Location			1	0d. Inside City Limits
Maryi -f sho	tor	MD Wicer	nico Fru	uitland				1 Nes 2 No
or 28e	Oirec	10e. Street and Number		10f. Zip Code			tizen of What Cour	ntry?
ath wi	ral	302 Park Ave	12. Was Decedent Ever in U.S.	2/			14. Race - Americ	an Indian.
be filed within 72 hours atter death with the Maryland tal Hygiene. d other than *natural', or ftams 23a or 28e-f show event, tre Medical Exercise must be coulified a	by Funeral Director	11. Marital Status  Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1   Yes 2   No If Yes, Give Year or Dates:	It Yes, specify Cu	Hispanic Origin? (Spe ban, Mexican, Puerto f o <i>Specify:</i>	Rican, etc.)	Black, White, Specify: 81	etc.
72 ho	Completed by	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occi (Give kind of work don	upation e during most of workinged)	16b. i	(ind of Business/Ind	dustry
within piene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	None			Nove	
d tal	Be	17. Father's Name (First, Middle, Last)  Richard HErr	m. 1 d			(First, Middle, Maide		me.(
should nd Men marke	To	40. Informatio Name (Deletingship (Tu	na Print)	10h Mailing Address (Stre	et and Number or Rura	Route Number City	or Town State Zin	Code)
and 2 salth a n 27 is		Patricia Thumas  20a. Method of Disposition	s-Mother	302 Park A	We-Fruitle	end, mel	21826	
ges 1 it of He if iten or oth		1 Burial 2 ☐ Cremation 3 ☐ P	emoval from State	be of Disposition (Name of netery, crematory or other p.	lace) 3/2	20c. t	ocation - City or To	own, State
permit. Pages Department of Important: If it		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	99 / 1	netery, crematory or other p n < h )     Memorial 22. Name and Add	Iress of Facility Bar	inie Smit	a turner	I Home
Department of the position of		23a. Part1. Enter the disease, or compl	Tool	917 W.I	Suballa St	-Sc1.5 b	ary, md	21801
Physician Personned by Physician and Physician and Physician and Physician are the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	nieu offic	257			Onset and Death
death certificate attending phy:	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 33c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal deal 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 Ectopic pregnar			23d. Date of detive	ery Day Year
# E D B	þ	Part It. Other significant conditions co	ntributing to death but not resulti	ing in the underlying cause	given in Part I.		use contribute to the	he cause of death? pably 4 Unknown
lor Attending Physicien: The law requires that the late death.  Director: After this certificate has been signed by the 1 in by the funeral director, page 2 should be detache.	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
cien: ertifica actor,	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death	(Check only one)		
Physi r this c	5	1 XYes 2 No  27. Manner of Death	1 Linpatient 2 Lie	8b. Time of 28c. fr	4   Nursing Hor	me 5 Residence 28d. Describe how inj		(y)
Attending Physicien: r death. ector: After this certific by the funeral director,	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		Whown AM 1	□Yes 27No		WAS SHOT	
DIVISION Attendent after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specity)	ve, farm, street, factory, office	ce	28f. Location (Street a City or Town, Sta	te)   Znd S	
To the Hospitel or Attending Physical Committee of the Hospitel or Attending Physical States and To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	sician: To the best of my knowledge: On the basis of examination and manner stated.	ledge, death occurred at the	o time, date and place, y opinion, death occurr	and due to the cars- ed at the time, date a	s) and manner as s nd place, and due t	itated. o the cause(s)
To the swithin 2 To the complete	Me	29b. Signature and title of certifier	M. H	29c. Lice OCMI	anse number E		ate signed (Month, ebruary 1	
	State	30. Name and address of person who of the state of the st	ompleted cause of death (Item 2)  (M), (M),  32. Registrar's Signatu	111 1	Penn Street	., Baltimon	re, Maryl	and 21201

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

& Sparks

FEB 1 9 2004

			For State Registrar	State of Marylan		artment <i>rtificate</i>			-	giene Reg. No.	2004	07103	
Ping S			1. Decedent's Name (First, Middle, Last)					-	2. Date of De.	Day	Year	3. Time of Death	
187	Physici /Medio		Doris Le	ee		Marsha	all		Februar	4020	2004	0906 M	
	Examin		4a. Facility Name (If not institution, give s PENINSULA REGISMA!	treet and number)  MUICAL CON	M	51	10/560	1		) 4c. C	County of Death	ath 11Co	
	Funeral Director		220-32-0169	077 -	last birthday)	If Under 1 Months		Mder 24 Hrs ours Min.	8. Date of Bin (Month, Da December	y, Year)	9. Births Cour 1931 Sali		
	iand ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or L	ocation					1	10d. Inside City Limits	
	e Many 3e-f sh tilfed	Director	Maryland Wicomico	Fru	itland							XXYes 2 ☐ No	
	with th	Dire	10e. Street and Number			10f. Zip 0					en of What Coul	ntry?	
	eath is 23	erai	211 Hayward Avenue	2. Was Decedent Ever in U	.S. 13.	2182 Was Decede		nic Origin? (S		USA 14	4. Race - Americ	can Indian,	
980	be filed within 72 hours after death with the Maryland tal Hygiene.  Ad other than "natural", or items 23s or 28e-f show other than "natural", or items 23s or 28e-f show event, the Medical Exeminer must be mailied at	by Funerai	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Il Yes, specif		exican, Puerl	pecify Yes or No to Rican, etc.)		Black, White, Specify:Whit		
21215-0036	72 hor	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual	done durin		rking	16b. Kind	d of Business/In	dustry	
121	filed within Hygiene. Ither than out, the Met	idmo	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		DO NOTUSE ate Sit				Care	Giver		
d 2	Hygie other	0	17. Father's Name (First, Middle, Last)		PLIVE	ice or		Mother's Na	me (First, Middle,				
Maryland	should be ind Mental marked c	To B	Roland	Hudson				ary	Etta		vis		
Man	0 6 6 0		19a. Informant's Name/Relationship (Type Randy Marshall - S			-			ural Route Numbe lisbury,				
	Health Health tem 27 other tr		20a. Method of Disposition	20b. I	Place of Disp	osition (Name	e of	ia, ba.	Date		ation - City or To		
E O	Pages nent of I ant: If it		1XXBurial 2 ☐ Cremation 3 ☐ R.  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre inchill			s 02/2	5/2004	Hebr	on, Mar	yland	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	98	Î		Address of	feral I	Home Pro	fessi	onal As	sociation and 21804	
	**		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the deal							Maryia	Approximate Interval Between	
8760,	Physician /Medical Examiner sician and ponujal-transit	cal Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):	CHT I	IV(C)	WITH L	LEFT HEA	MPLE	:01/P		
P.O. Box 687	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	al death 3	□Ectopic pre				23	3d. Date of delive	ery Day Year	
	signed by	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the (	underlying ca	use given in	Part I.		obacco us Yes 2□		he cause of death?	
Vital Records,	The law requires that the ste has been signed by th bage 2 should be detache	Completed	HYPERCHOLESTE	POLEMIA.					24a. Was auto perfo	osy ormed?	death?	opsy findings available impletion of cause of	
tal			25. Was case referred to medical				26	. Place of De	1 ☐ Yes ath (Check only o	2 No	1 ☐ Yes	2™No	
	× 5 ₽	To Be	evaminer?	lospital: 1 Inpatient 2	] ER/Outpatie	ent 3 DO	Othor	160-	Home 5 ☐ Resi		Other (Special	(y)	
ion of	ding After fune		27. Manney of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date ol Injury (Month, Day Year)	28b. Time of Injury	of 28	Bc. Injury at Work? 1  Yes	2 🗆 No	28d. Describe	how injury	occurred		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, s	treet, factory,	office		28f. Location ( City or To		l Number or Rura	al Route Number,	
	To the Hospital within 24 hours a To the Funerel Completely filled	edical C		sician: To the best of my kn ner: On the basis of examin and manner stated.									
	To the Hawithin 24 To the Fe complete	Me	29b. Signature and title of certifier			29c.	License nu	mber		29d. Date	signed (Month,	Dey, Year)	
		white the same	Maherler	VI N	10	D		605		2/	120/0	4	
6			30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type	e, Print)	14 B	EA	STERIN	SHOR	E DE		
4	X St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature /		HLISI	SURY	/	VIU	2180	-4	
	Regist		FFR 2 3 200	14 Beneva		200	uks						

			1 - For Registrar	State of Marylai	nd / Depa <i>Cei</i>	artment of H	ealth and I	Mental Hyg	iene20	04 0710	Ļ	
	Physici		Decedent's Name (First, Middle, Last, LOTTIE	CATHERINE	MILLE	R		2. Date of Deat Month	h Day	Yeer 3. Time of Death	М	
	/Medio Examin		4a. Facility Name (If not institution, give PENINSULA REGIONAL	1	Wood	4b. City, Town, or	11/11/11		4c. County			
2	Funeral Director		5. Social Security Number 6. Sec 212-05-8826	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 8,		9. Birthplace (State or Fore Country) Maryland	ign	
	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at	tor	10a. State 10b. County  Maryland Wicomico		ity, Town or Lo					10d. tnside City Limi 1 ☐ Yes 2反		
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of W	Vhat Country?		
	ns 23e	erai	32728 Mt. Hermon	12. Was Decedent Ever in U		21849 Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	USA 14. Race	a - Americen Indian,		
920	al, or iter	by	1 Never Married 200 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	f Yes, specify Cuba	n, Mexican, Puert Specify:	o Rican, etc.)	Specify.	k, White, etc. 		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examination and the notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usuat Occupa kind of work done o DO NOT use retired	luring most of wor	rking	16b. Kind of Bu	siness/Industry		
27	filed wi Hygien ther th		8 17. Father's Name (First, Middle, Last)	_	Home	maker	18 Mother's Nar	ne (First, Middle, M	Domes			
Maryland	Aental rked o	To Be	Uriah M. Woutten				Lottie		acon	5,		
Mary	2 should and Men ie marke raumatic		19a. Informant's Name/Relationship (Ty			g Address (Street a						
	tond Health tem 27 other tr		Frank J. Miller/h	20b.	Place of Dispo	sition (Name of				MD 21849 City or Town, State		
E	Pages nent of I ant: If its arry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place Memory Gard		19/04	Hebror	n, MD		
Baltimore,	permit. Departr Importe any inje		21. Signature of Funeral Service License		22	Name and Addres	s of Facility Funeral	Home Prof	ession:	al Associatio	n	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea e cause on each line.						Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (ar as a consec	$\frac{SiS}{S}$							
	Examiner		Sequentially list conditions,	Preu	Moni	q						
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quenea of).							
o,	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
8760,	icate be ex physician the buria	dical		l								
.O. Box 6	ath certif attending for use as	Physician/Me	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	at death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year	
٥.	es that the deigned by the be detached	by Ph	Part II. Other significant conditions cor	tributing to death but not res	sulting in the ur	iderlying cause give	n in Part I.	23e. Did tob	acco use contri	bute to the cause of death?		
ords	w requires been sign should be	ted b						1 ☐ Ye	s 2 No	3 Probably 4 ⊞thknow	'n	
Il Records,		Completed						24a. Was an autopsy perform	ed? pr	/ere autopsy findings availab rior to completion of cause of eath? □ Yes 2 □ No	le	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2550	Othe		th (Check only one				
Division of	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing H	ome 5 Resider 28d. Describe how				
Divisi	nl or Attending Ph after death. Director: After th d in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)			eet and Numbe State)	or Or Rural Route Number,			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in It.	edical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	lician: To the best of my known on the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the car rred at the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)		
	To the within Z	Me	29b. Signature and title of certifier			29c. License			. T	(Month, Day, Year)		
			30. Name and address of purson who co	moletal page of death (the	m 23a\ /Tune	//33 Print)	438		2/1	6/2004		
0			FIANK APPIN	2, M.O. 40	20 L.	Print) Shore 4	Dr. 54	1 L136/1	no			
	Sta Registr	40.0	31. Date filed (Month, Day, Year)  FFR 1 9 20	32. Registrar's Signa		Spark						

State of Maryland / Department of Health and Mental Hygiene  $200 \, \mathrm{L}$ 07105 Certificate of Death 2. Date of Death 1. Decedent's Name\_(First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OMICO Salisbury
Inder 1 Year | If Under 24 Hrs. MOME nenorac 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Oay, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 X M 2 □ F 219-07-2646 84 Director December 6,1919 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-1 show other traumatic event. the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 826 S. Schumaker Dr., Apt. 204 21804 or Items 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 21 No þ If Yes, Give Year or Dates: Army Specify Specify. white 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker US Postal Service permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg. Important: If tiem 27 is marked other any injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morgan Henry Alice Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) anna May Morgan.wife 826 S. Schumaker Dr., Apt.204, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2/23/04 Salisbury, MD <sup>22</sup>, Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Sign ulm of Puneral Service Licensee 234. Papt. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Po not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Tumon Dladder 2 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a nonsequenza offi-Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. | 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 1 Yes 2 Ho 3 Probably 4 Unknown cate has been si page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1□ Yes 2ºNo or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient Other: 1 Tyes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year) meris February 515+ 2004 0057359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UThe NATESAN 1415 ST MD 21804 DIVISION 5 SALISBURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2004 Registrar

		•	1 - For State Registrar	State of Ma		nd / Depa		of H	ealth a	and N	F	jiene leg. No. (	20(		07	106
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	Day	)	rear_	3. Time of	
	/Medic	al	HERBERT CAMDEN ME				4b Ciby	Tourn or	Location	of Dooth	FEBRUAR		20 County of		6:55	5 P <sup>M</sup>
Н	Examin	er	4a. Facility Name (If not institution, give DENNETT ROAD MANO)		ном:	F		LANI		JI Death		40.	•	RRET	т	
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н	Director		213-18-2694	XIM 2□F 82		Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day NOV 16,	192	.1	MAT	YLAND	)
	and		Usual Residence of Decedent  10a, State 10b, County		10c. Ci	ity, Town or Lo	cation							10	od. Inside C	ity Limits
	Maryl.	ō	MD GARRETT		0.	AKLAND										2 <b>∑</b> No
	r 28a	Director	10e. Street and Number				10f. Zip	Code			1	l0g. Citiz	en of Wh	at Count	ry?	
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Maryland 21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	Year or Dates:							1					
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			P. DANIEL MILLES  31. Date filed (Month, Day, Year)	R, D.O.		WOLF ature	ACKES	DKI	.VE	UAK.	LAND, MI	215	<b>5</b> U			
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Ball	permit. Pagas. Department of h Important: If its any injury or of		21. Signature of Funeral Se	vice Lice	Nº Den	J	22	Stewa 32 S.	irt F	unera	ат но	me ∪aklan	id , 1	MD 215	50_		
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	To th withir To th comp	Me	29b. Signature and title of c	ertifier					. License					ate signed (M	fonth, i	Day, Year)	
,	2		30. Name and address of pe	rson who	completed caus	se of death (Ite	em 23a) (Type		01533	33			2/1	8/04			
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		th with the 23a or 28a	i Direc	10e. Street and Number 308 HEMSLEY DRIVI	E		10f. Zip Code 21658			itizen of What Country?	
Dixie	920	after dea or Items	by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:	If	/as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto F Specify:	city Yes or No-	14. Race - American In Black, White, etc. Specify: WHITE	
S	1215-003		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occupation kind of work done dur O NOT use retired)	on ing most of working	ng	. Kind of Business/Industry	
Morri	Maryland 21	ould be filed Mental Hygia srked other atic event. I	To Be Col	11 17. Father's Name (First, Middle, Last, GEORGE CHARLES RA		AUDIT			(First, Middle, Maide.  E RADCLIFF.		
		± 2 € g		19a. Informant's Name/Relationship ( CARL A. MORRIS/HI	JSBAND	308 H	EMSLEY DR	, QUEENS	STOWN, MD	or Town, State, Zip Code 21658	
	Baltimore,	0 0		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specif.	Removal from State	emetery, crem	ition (Name of atory or other place) K CEMETERY			ocation - City or Town, S	
	Balt	permit. Pag Department Important: h any injury o		21. Signature of Funeral Service Licer	The Light	FE	Name and Address LLOWS, HEI 6 SHAMROCK	FENBETN	& NEWNAM HESTER, MD	FUNERAL HOMI 21619	
		Physician /Medical Examiner	je.	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate	plications that caused the death one cause or each line.  a	lience of):	1		r respiratory arrest,	Applinter Ons	
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		the Hosp in 24 hou the Fune ipletely fil	Medical	(Check only 2 Medical Examone)	nysician: To the best of my knowniner: On the basis of examinate and manner stated.	wledge, death ion and/or inve	estigation, in my opin	ion, death occurre	ed at the time, date an	d place, and due to the o	
		To To	Σ	29b. Signature and title of certifier	5/1/1/		29c. License n	umber	29d. Da	ate signed (Month, Day,	

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

10b. County

QUEEN ANNE'S

DIXIE MORRIS

5. Social Security Number

MD

218-40-7300

Usual Residence of Decedent

**Physician** 

/Medical

Examiner

Ö

**Funeral** 

Director

-f show Ded at Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Memorial Hospital

7. Age (In yrs. last birthday)

10c. City, Town or Location

**QUEENSTOWN** 

60

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 1 14

4b. City, Town, or Location of Death

Easton

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)

2. Date of Death Month

February

Day

SEPT. 5, 1943 MARYLAND

Year

20, 2004

Talbot

14. Race - American Indian, Black, White, etc. Specify: WHITE

STATE GOVERNMENT

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

4c. County of Death

FFE r, City or Town, State, Zip Code) 21658 20c. Location - City or Town, State STEVENSVILLE, MD AM FUNERAL MD 21619 HOME, P.A. Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Dav pacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ence 6 Other (Specify) how injury occurred Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month; Day, Year) D0053602 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) CAROLYN HELMLY M.D., 503 CYNWOOD DRIVE, EASTON, MD 21601 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Year) 32. EB 2.6 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State AMEND ITEM #21 PER DVR G829 3/09/04 Dertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 18;38 Frances Ann Mitchell February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 700 West Bel Air Ave Apt 227 Aberdeen Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Yeer) May 18 1940 Birthplece (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2√2 F 63 Director 213-36-8709 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow item 27 is marked other than "natural", or Itams 23a or 28a-f abov other traumatic avant, the Medical Exercises must be coulded at 1 Yes 2 No Directo Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 700 West Bel Air Ave Apt 227 21001 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If from 27 is marked other than "natural; or Itan any injury or other traumatic avant, the Medical Exercises-Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Vending 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard L Collier Sr Joyce A Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna G Seibert (Daughter) 641 Frans Dr Abingdon Md 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Donation 5 ☐ Other (Specify) Harford Memorial Gardens 2/9/2004 Aberdeen, Maryland PER DVR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home P.A. Aberdeen, Maryland 21001-3399 KIRSTEN AMY UNGLESBEE MOO911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as IF FEMALE use : 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð RHELMOTOID ARTHRITIS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? HYPERTENSION 2 X No 1 ☐ Yes 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 24 hours after of Funeral Direct 4 T Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 41614 February 5,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 Campbell Blvd Baltimore, Maryland 21236 DR ALAN B Halle MD 2. Registrar's Signature 31. Date liled (Month, Day, Yeer) State MAR 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Lest) Month Feb. **Physician** 2004 5:25 AM ROBERT LUND OLIVER /Medical 4b. City, Town, or Locetion of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 01-10-1927 6. Sex ⅓ M 2 □ F 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Days 77 NEW JERSEY Director 148-14-9050 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Haaith and Mantal Hygiene. Int: If them 27 is marked other than "natural; or items 23s or 28s-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural; or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director SUSSEX ELLENDALE DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22197 REYNOLDS POND ROAD 19941 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status TX☐ Yes 2☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Ot.IVER Maryland 21215-0020 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VICE PRESIDENT BANKING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID RAYMOND OLIVER HILDEGARD LUND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22197 REYNOLDS POND ROAD, ELLENDALE, DE. 19941 GLADYS OLIVER - SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dapartment important: If MELSON'S CREMATORY 2-23-04 FRANKFORD, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SHORT FUNERAL SERVICES 21. Signature of Funeral Service Licensee low 416 FEDERAL STREET, MILTON, DELAWARE, 19968 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Attanding Physician: The law raquiras that the death certificate ba executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the bunal-tran Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): eral Director: After this cartificate has been signed by the a filled in by the funeral director, paga 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No TE YOU TEN 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) / No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: edical Certification: To 1 ☐ Yes 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Menn of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Al aturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ö To the Hospital of within 24 hours at To the Funeral D critifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1346 S. Division St.Suite, Salisbury, Md.21804 WILLIAM ROBBINS, MD 31. Date filed (Month Bay, Year) FEB 2 3 2004 32. Registrer's Signature State Registrar **DHMH 16 Rev 6/95** 

			Please	e Type of Print in Black indelible ink. Ensure All Copies Are Legible	<b>!-</b>
			For State Registrar	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 200	14 07111
	Physici /Medio	cal	1. Decedent's Name (First, Middle, L	KEYES PERALTA Month , 28. 00	3. Time of Death  4 7 4 5 fm
	Examir	ner	4a. Facility Name (If not institution, g	GEORGE HOSP ChereRIV PRIN	JCE DEOFGE
	Funeral Director		5. Social Security Number  NONE  Usual Residence of Decedent	1. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Vrs. 8. Date of Birth (Month, Day, Year) 9. If Under 24 Vrs. 4. Min. (Month, Day, Year) 9. If Under	Birthplace (State or Foreign
	Maryland -f show fled at	tor	10a. State 10b. County	10c. City, Town or Location  RIVERDALE	10d. Inside City Limits  1 ▼Yes 2 □ No
	with the	i Direc	10e. Street and Number	iverdale Rd 10f. Zip Code 10g. Citizen of What	Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evandum tring the Lydified at ADGE.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W	merican Indian, /hite, etc.
21215-0036	within 72 hor ene. then "natura for Medicul E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Fig. 16b. Kind of Busine	ss/Industry
	d be filed with ntal Hygiene. ed other ther event, tre N	Be	17. Father's Name (First, Middle, La.	18. Mother's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)	PAITA
, Maryland	1 and 2 should be Health and Mental Iom 27 is marked of other traumatic ever	To	NARCISD  19a. Informant's Name/Relationship  NARCISO	REYES-FATHER 5322 RIVERDALE Rd Ri	JESTALIA VESCARMO
Baltimore	Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control		or Town, State
Ball	permit. Pag Department Important: any injury c		21. Signature & Furleral Service Lie	22. Name and Address of Facility  STEPLING FUNERALSVC. S	O STERLING STERLING, V
	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or beart failure. List on Immediate Cause (Final disease or condition resulting in death)	_aSEP513	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, a any, leading to immediate	b. Due to (or as a consequence of):  b. Due to (or as a consequence of).	1
35	be executed ician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	c. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of):  LONGENITAL HEART FAILURE	
Box 687	The law requires that the death certificate be executed the bas been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Completed by Physician/Medica	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	delivery Day Year
P.O.	at the de	Physic	1 Yes 2 No 9 Unknown	9□ Unknown	A Aba an an an at density
	equires then signed and be d	ted by	ON GENIT		Probably 4 Unknown
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Vita	ystcian s certific director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (Check only of e)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S	ipecify)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)  28b. Time of Security 1   28c. Injury at Work?  1   Yes 2   No	<i>500.19</i> )
Divi	tal or Attendi rs after death. al Director: A ed in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not determine		Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner xeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and cand manner stated.	as stated. due to the cause(s)
	To t Com	Σ	29b. Signature and fitle of certifier	29c. License number 29d. Date signed (Mc	Sonth, Day, Year)
			30 Name and address of person wh	no completed cause of death (Norm 23a) (Type, Print), Com BerBATCH 8416 Central AUE landows	er md 2078:
**	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	ÄR 0 9 2004 Magnes & South	

			1 - For State Registrar	State of Ma			rtment of tificate of			-	-		) 4	0711
			Decedent's Name (First, Middle, Last	t)						2. Date of De	aath			3. Time of Death
	Physic /Medi		Robert Cha	rles S	Schenroc	ck				Month	Day i S	3 20	ort	18:20PM
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				nome Ma	Ucal Cer	nkr	SAL	isbu	ry			Wi	Con	nico
п	Funeral		5. Social Security Number 6. Se	MM 20E	(In yrs. last bir	rthday) Yrs.	Months Days			8. Date of Bir (Month, Da	ay, Year)			ce (State or Foreign
ja.	Director		Usual Residence of Decedent	76	)	115.				April 15	, 192	27 Pe	nnsy.	lvania
	/land		10a. State 10b. County		10c. City, Town	n or Loca	ation						100	d. Inside City Limits
	Mary First	to	Maryland Wicomico	,	Salisk	hiira								1 ☐ Yes Z∏No
	r 28s	rec	10e. Street and Number		DOTIDI	<u>our y</u>	10f. Zip Code				10g. Citi	izen of Wha	t Countr	y?
	72 hours after death with the Maryland naturel', or Itama 23a or 28a-f ehow disal Examerat mer must be notified at	Funeral Director	32208 Bonhill Driv	ve			21804	1			US	SA		
	ama ama	ner	11. Marital Status	12. Was Decedent E Apped Forces?	ver in U.S.	13. W	as Decedent of Yes, specify Cut	Hispanic O	rigin? (Spe	cify Yes or No	)-	14. Race - A		
98	or It	y Fu	1 ☐ Never Married 2X Married	1 Yes 2 N			☐ Yes 2 No			iloan, otc. j		Black, V Specify:	vnite, et	c.
8	nours urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: A	_								Whit	е
21215-0036	n 72	Completed	15. Decedent's Edu (Specify only highest grad	ication de co <i>mpleted)</i>	16a.	(Give ki	ont's Usual Occu ind of work done O NOT use retire	during mo	st of workir	ng .	16b. Ki	nd of Busine	ess/Indu	stry
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	fited withi Hygiene. other then		17. Father's Name (First, Middle, Last)			TIRE	ring/Mena	-	ner's Name	(First, Middle,		nicati	ans (	cmpany
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, Lie M.	To Be	Robert Charle	es Sch	enrock				/dia	(* *****) *****************************		Sobe	l-	
37	should nd Men marke umatic	-	19a. Informant's Name/Relationship (T)			. Mailing	Address (Stree			Route Number	er. City o			ode)
	and 2 salth a n 27 is	ĺ	Lois Anne Schenro	ck (wife			conhill Dr						-, -,	,
ē,	_ 7 5 5		20a. Method of Disposition		20b. Place of	Disposit	tion (Name of story or other pla			ate		cation - City	or Town	n, State
Ë	Pages nent of int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Denation 5 ☐ Other (Specify)		Salisbur				Februar	y 19, 200	V Sal	lichm	Mar	Fractive
Baltimore,	구두분증		21. Signature of Funeral Service Ligans		- COLLEGE									
m	Department of the partment of		1 14 160	Olyman		HC	olloway	Funer	Road.	me Pro	fess	ional . Mars	ASS	ociation d 21804
			23a. Part 1 Enter the disease, or complete shock, or heart failure. List only o	lications that caused	the death. Do n	not enter	the mode of dy	ing, such a	s cardiac or	respiratory ai	rrest,	/ Mar	A	pproximate
	Physician		Immediate Cause (Final	ne cause on each	P.	6.6	cic							nterval Between enset and Death
100	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence o		515						3	days
3	Examiner				,		unomo	V					5	days
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8760,	ate b	dical		d									1	
9 ×	death certifica attending ph of for use as t	Me	IF FEMALE:							7.11				
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death		ctopic pregnanc	y			2	3d. Date of Month	delivery Da	ıv Year
o.	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 🗌 C	Other (specify) _					101071171		, , , ,
<u>α</u>	that the ed by detac		Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the und	erlying cause an	van in Part		23a Did to	abacco III	sa contribut	a to the	cause of death?
ds,	es Ou	d by	•	<b>g</b>			onlying occoso gi	von mi v care	**		/es 2			y 4 DUnknown
Ö	w require been si should t	ete								-		1		
Records,	has has	Completed								24a. Was autop perfo	sy	24b. Were prior death	to comp	r findings available letion of cause of
		ပို	25. Was case referred to medical							1 Yes	2 1 No	1 🗆 Y		] No
Vital		o Be	examiner?	lospital:			Ott			(Check only o				
			27. Manner of Death	28a. Date of Injury	28b. T	ime of	3□ DOA 28c. Inju	4 🗆 14		e 5 🗌 Resid			pecify)	
on	Too way in	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) In	njury		rk? ]Yes 2.⊟						
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	ry - At home, far	rm, stree	t, factory, office		21	3f. Location (S	Street and	Number or	Rural R	oute Number,
	spital or ours afte teral Dira filled in t	Sert	4   Homicoe	building, etc.	(Зреспу)					City or Tow	m, State)			
	Hospital 24 hours 2 Funeral I		29a. Certifier 1 Certifying Physical Exami	sician: To the best of	my knowledge,	, death o	ccurred at the ti	me, date ar	nd place, ar	nd due to the d	cause(s)	and manner	as state	d.
	To the Hos within 24 h To the Fun completely	Medical	one)	ner: On the basis of and manner state	ed.	2/or inves	stigation, in my o	opinion, dea	ath occurred	at the time, o	date and	place, and c	lue to th	e cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	. / 1			29c. Licens	se number		1		signed (Mo		
•			> whenely Vel 1	VATESON	MD.		De	5739	59		2.	-19-	200	4
11			30. Name and address of person who co		ath (Item 23a) (	Туре, Ргі	•							
IN	XX			JISION ST	, SALI	SBU	RY M	D 780	4					
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 9 20	32. Registrar	s Signature	4	home	/ /						

Robert Schenrock 204-13-0425

			1 - For State Registrar	State of Ma	ıryland	/ Depa	artment d <i>tificate</i>	of Health of Death	and Me	ntal Hygie	20 C	) 4	07113
			1. Decedent's Name (First, Middle, La	st)					2	. Date of Death Month	_	rear	3. Time of Death
	Physici /Medio		RODNEY (	CARL SE	ENKBEI	L				EBRUARY	16,200	4	12:11 💆
	Examin	er	4a. Facility Name (If not institution, give 26664 Nanticoke I				•	vn, or Location	of Death		4c. County of		
			5. Social Security Number 6. S	N	(In yrs. las	t birthday)	If Under 1 Y	sbury	r 24 Hrs. g	Date of Birth	Wico		
	Funeral Director			CTT OF T	59	Yrs.	Months D	ays Hours	Min.	Date of Birth (Month, Day, Y	1934		ace (State or Foreign try) yland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					11	Od. Inside City Limits
	f sho	ō	Maryland Wicomic			isbur							1 ☐ Yes 2 ☑ No
	28a-	Directo	10e. Street and Number	.0	Dai	ISDUL	10f. Zip Co	de		100	j. Citizen of Wh	at Coun	try?
	h with	ai Di	26664 Nanticoke	Rđ			21	801			USA		
	ama (	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Decedent Yes, specify	of Hispanic O Cuban, Mexica	rigin? (Speci	fy Yes or No-	14. Race -	America White, 6	
36	be filed within 72 hours after death with the Maryland stal Hyglene. ed other then "natural", or Itama 23a or 28a-f show event. The Medical Examinar must be motified at		1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 📆 Yes 2 🗖 N If Yes, Give Year or Dates:	_		☐ Yes 2 🔀			,	Specify:		ite
8	2 hou	ted t	15. Decedent's Ed	ducation		16a. Deced	lent's Usual O	ccupation		16	6b. Kind of Busi	ness/Ind	ustry
21215-0036	thin 7.	Completed by	(Specify only highest gra	de completed) College (1-4or 5-	+)	(Give lite. L	kind of work d OO NOT use re	one during mo etired)	st of working				
	filed wil Hygien othar th	Соп	8	_		Carr	enter				Carpen		
Maryland	t be fit ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  Gust Senkbeil							First, Middle, Ma loyd	iden Sumame)		
<u> </u>	should be ind Mental   a marked o	10	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	a Address (St			Route Number, (	City or Town. St	ate. Zip	Code)
Š	12 7 in 7		Helen R. Senkbeil							Salisbu			
altimore,	es 1 a of Hea fitam r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State	20b. Plac	e of Disponetery, cren	sition (Name o	of place)	Dat	9 20	c. Location - Ci	ity or To	wn, State
Ĕ	Pag ment tant: I		*4 □ Donation 5 □ Other (Specify		Socir	qhill	Memory (	ardens	2/20/0	04	Hebron	MD	
Bai	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Licer	1598		F	Iollowa	ddress of Facil y Funer	cal Hor	me Profe	essiona.	l As	sociation
			21a Part 1. Enter the disease, or com	plications that caused	the death.	Do not ente	OL Sno or the mode of	W Hill dying, such as	Rd., S s cardiac or r	Salisbur espiratory arres	y, MD	2180	Approximate
	Priysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each un	e. Lung	ean le							Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or as a									
	Examiner	L	Sequentially list conditions,	b									
	rted nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	nce or):							
Ć.	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):			"		···	_	
8760,	ficate be executed physician and s the burial-transit	edicai		d									
9	ertifica ling ph e as t	Med	IF FEMALE:								1	1	
Вох	eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1	2 ☐ Fetal de	eath 3	Ectopic pregn Other (specif				23d. Date of Month		y Day Year
P. O.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	and or dou	5_	Ottier (specin	//					
	res that igned b be deta	by PI	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ng in the ur	derlying caus	e given in Part	l.	23e. Did tobac	cco use contribi	ute to the	a cause of death?
ğ	w require been sig should b								II	1 🗆 Yes	2 □ No 3	☐ Proba	ibly 4 🗹 Unknown
ec	Attanding Physician: The law requires that the death certif cleath.  cros Alth.  cros Alth.  y the funeral director, page 2 should be detached for use a.	Completed								24a. Was an autopsy	pric	re autop or to com ath?	sy findings available ipletion of cause of
<u>a</u>	hysician: The law his certificate has b I director, page 2 s									performe 1 ☐ Yes 2 ☐	No 1	Yes :	2 🗷 No
₹	sicial	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	t 2∏ EF	8/Outnation	3 □ DOA	Othor		5 Residence	o 6 □Othor	(Specific	
10	g Phy er this ieral c		27. Manper of Death	28a. Date of Injury (Month, Day	/ 28	Bb. Time of Injury		Injury at Work?		d. Describe how			
jo	ttanding P Jeath. tor: After t	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1	7041)	injury		1 Yes 2	]No				
Division of Vital Records,	To tha Hospital or Attant within 24 hours after deatt To the Funaral Diractor: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry · At homi . <i>(Specify)</i>	e, farm, stre	eet, factory, off	ice	28f	Location (Stree City or Town, S		or Rural	Route Number,
_	To tha Hospital or within 24 hours afte To the Funaral Dir. completely filled in I		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowle	edge, death	occurred at th	ne time, date a	nd place, and	due to the caus	se(s) and mann	er as sta	ited.
	To tha Hospital within 24 hours or To the Funaral completely filled	Medical	(Check only 2 Medicel Exam	niner: On the basis of and manner stat	examinatior	n and/or inv	estigation, in r	ny opinion, de	ath occurred	at the time, date	and place, and	due to	the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier				29c. Lic	ense number		29d	. Date signed (/	Month, D	Pay, Year)
			Nafem					1470	94		2/18	104	
1			30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type, I \$ · <b>b</b> iv	rint)	sher	SM	45BUP	1 ~0	218	304
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 1 9 2	004 Sen	r's Signatur	6	Spa	Ms		29d			

STOKES, Alice 241-40-6213 Baltimore, Maryland 21215-0036 Division of Vital Records. P.O. Box 68760.

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Manyland / Department of H	solth and Mantal Lluciana

			1 - For State Registrar	State of Maryland		artment of Fi tificate of		-	giene Reg. No. 2	nnı	07111
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		ALICE CARY	STOKES				Month O2	Day	O 4	0023 M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	1.	4b. City, Town, o	Location of De	ath		unty of Death	
			PENINSULA KEGIONA	al Medien 1	INTU	54	113641	4		HIBM	
	Funeral Director		5. Social Security Number 6. Sex	M 287F	ast birthday) Yrs.	Months Days	If Under 24 H Hours Mi	n. (Month, Da	y, Year)		plece (State or Foreign intry)
T			241-40-6213 Usual Residence of Decedent	86				August 5	5,1917	Nor	th Carolina
200	ahow Lat		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
N C	e III	cto	Maryland Somers	et P	rinces	s Anne					1 ☐ Yes 2 🔀 No
with th	Per 2	Directo	10e. Street and Number 11038 Brownstone	n a		10f. Zip Code				of What Cou	intry?
dath y	16 23 Part	Funeral		RU •  2. Was Decedent Ever in U.:	S 13 V	218		(Specify Yes or No	USA	Race - Amer	ican Indian
fter d	r Hen	F	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 □ No	11	Yes, specify Cuba	ın, Mexican, Pue	erto Rican, etc.)	14.	Black, White	
ours a	France France	1 by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐xNo	Specify:		Sp	өсіfу: Wi	nite
72 h	nato	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occup kind of work done	durina most of w	orking	16b. Kind	of Business/l	ndustry
within	than than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	1)		Ноэ	lth Cai	•
be filed within 72 hours after death with the Maryland	Hygi other		17. Father's Name (First, Middle, Last)		Sitt	er	18. Mother's N	ame (First, Middle,			.e
d b	Red c	To Be	Israel E. Stocks					McLawho		•	
should	and N e mar	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street	and Number or F	Rural Route Numbe	er, City or To	wn, State, Zi	p Code)
and 2	n 27 I	Ü ,	Yvonne S. White/d		11	038 Brown	nstone F	Rd., Prin	cess A	nne, M	ID 21.853
Pages 1	Department of Health and Mental Hygiene. Important: or fleme 23a or 28e-f ahov any injury or other treumatic avent, the Medical Examinar must be notified at once.		20a. Method of Disposition  1  ↑  ■ Burial 2 □ Cremation 3 □ Recommendation 2 □ Recommendation 3 □ Recommen	emoval from State	ace of Dispos metery, cren	sition (Name of natory or other place	e)	Date	20c. Locati	ion - City or T	own, State
	rtant:		'4 □ Denation 5 □ Other (Specify)			Memory Gar			Heb	ron, M	D
permit	Depa Impo any ir		21. Sinnatur of Funeral Service Licen	00		Holloway	Funeral	Home Pro	ofessi	onal A	Association
			23a. Part1 Enter the disease, or complic	cations that cared the death				., Salislac or respiratory ar		MD ZIS	Approximate
PI	hysician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	1200	/					Interval Between Onset and Death
- 1	Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	)					UMYS
E	xaminer		Sequentially list conditions.	PNE	UMON	VIA					0445
þe	. Set	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cr'as a consequ	iarica of).						
xecut	icien and burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
The law requires that the death certificate be executed	attending physicien and for use as the burial-trar	dical E									
tificat	as the	ledic									
th cer	signed by the attendin d be detached for use	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d.	Date of deliv	,
e dea	the at	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (specify)				Month	Day Year
hat th	ad by detacl		Part II. Other significant conditions con	tributing to death but not resu	Iting in the un	derlying cause give	an in Part I	23e Did to	hacco use o	contribute to t	he cause of death?
uires	signe ld be	d by	•			gorying augus gree	21. II. 1 Care 1.		es 2□N		
W red	bluods	lete						24a. Was	an 24	Ih Were auto	ppsy lindings available
The ta	his certificate has b I director, page 2 s	Completed						autop	sy med?	prior to co	mpletion of cause of
in in	rtifica stor. p	a	25. Was case referred to medical				26. Place of De	1 □ Yes eath <i>Check on o</i>	2-2 No	1 🗆 Yes	2   NO
hyeic	this ce al direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 E	ER/Outpatient	3□ DOA Othe		Home 5 Resid		Other (Specia	(y)
ing P	fter t		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury oc	curred	
ttend	after death. Director: After th in by the funeral	cati	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injury At her	fort		Yes 2□No	201 Leastine (6	Man and A fe		10-11
or A	after Direc	Certification;	4 Homicide determined	28e. Place of Injury · At hor building, etc. (Specify,	ne, iarm, stre	et, ractory, office		281. Location (S City or Tow		under or Run	al Route Number,
o the Hospitel or Attending Physician:	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	edical C	(Check only 2 Medical Exemin	icien: To the best of my know er: On the basis of examinati	vledge, death	occurred at the timestigation, in my or	e, date and place	ce, and due to the courred at the time, or	ause(s) and	manner as s	tated.
the	thin 2 tha c	Med	one)  29b. Signature and title of certifier	and manner stated.		1 00 1:					
Ţ	M T OS					73	8353	-	1/1	12000	/
			30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	Print)		SALISB	421	1000	
Y			ReNe' Desmai	Als, n.b.	400 €	. shore	01.	SALISH	ung.	MD	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 3 20	32. Registrar's Signati	ure 4	loon	11		/		

			Tor Stete Registrar	State of Maryland	_	artment of		-	giene Reg. No	0001	07115
	Dharist		1. Decedent's Name (First, Middle, Last)	}				2. Date of De			3. Time of Death
	Physici: /Medic		Walter Hans	SCHAEFER				Februa			5 25 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,		Death	4c.	. County of Deat	th
			Dennett Road Mano			Oak]		4 Hrs.   9 Date of Bi		Garr	
	Funeral Director			7. Age (In yrs. la ₹M 2□ F 88	Yrs.	Months Days		Min. (Month, Da	ay, Year)		hplace (State or Foreign buntry)
			Usual Residence of Decedent	- 00				Jan 2	19	10 New	York
	ylanc how		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Ma ta-fs	당	WV Prest	on	T	erra Alt	a				1 ☐ Yes 2 ☑ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	ountry?
	d within 72 hours after death with the Maryland sleep, then "naturel", or Items 23e or 28a-f show the Madical Examiner must be notified at	Funeral Director	671 East Alpine Dr		101		764	2 (0 - 1/2)		USA	dana tadia
	ltem refr	.n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	5. 13.1	was Decedent of f Yes, specify Cul	oan, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Ame Black, White	
ક્ટ ક	irs af	by F	3 ☑ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWI]	I .	1 ☐ Yes 2 🎇 No	Specify:			Specify:	White
ž	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	lent's Usual Occu	pation	of constring	16b. K	ind of Business/	Industry
	within 72 ene. then "na	adr De	(Specify only highest grade	Coilege (1-4or 5+)	life. L	DO NOT use retire	<b>∍</b> d)	or working			
71	filed wi Hyglen other th	Completed	llth		Mai	l Carrie					1 Service
ב	e d la b	Be	17. Father's Name (First, Middle, Last)	a				s Name (First, Middle	, Maiden		
چ	should be filed ind Mental Hygi s marked other umatic svent, I	၉	John Walter  19a. Informant's Name/Relationship (Ty	Schaefer	40h Mailia	- 4 / 6	Sign		- 01:		ansen
_	2 a a a a a a a a a a a a a a a a a a a		Carol Wierzbicki/D					or Rural Route Numb			
	1 and Health em 27		20a. Method of Disposition	20b. Pfa	ace of Dispo	sition (Name of		Terra Alt		V 2676 ocation - City or	
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		natory or other pla cematory		2/17/2004		•	
	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licental	515	0	. Name and Addr	1			rgantown	
ä	Dep Imp		Pielo H	The same		2 S. Sec		Stewart oakland	Fune M		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death.						2 2133	Approximate Interval Between
	nysician		Immediate Cause (Final		1 1	T					Onset and Death
	/Medical		disease or condition resulting in death)	Acute Myoca  Due to (or as a consequ		Infarct	lon				Immediate
	Examiner		Conventially list conditions	Coronary Ar	tery	Disease					Years
	D =	ner	Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	D							
760,	death certificate be executed e attending physician and of for use as the burial-transit		100011119 111 0001117 1201	Due to (or as a consequ	ence or):						
8/	physi physi the l	dlcal		d							
9 X	leath certific attending p	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pregnan	ncy					23d. Date of deli	verv
ă	atter 1 for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnand Other (specify) _	у		Ĩ	Month	Day Year
		hysi	9 Unknown	9□ Unknown							
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions cor	ntributing to death but not resul	lting in the ur	nderlying cause g	ven in Part I.	23e. Did t	obacco u	use contribute to	the cause of death?
ğ	w require been sig should b	edt	COPD					11	Yes 2	□ No 3 □ Pro	obably 4 XUnknown
ပ္က	aw re Is be 2 sho	plet						24a. Was		24b. Were au	topsy findings available completion of cause of
ř	The ate h page	Completed						perfo	rmed?	death?	
<u>=</u>	entifica ctor,	Be (	25. Was case referred to medical examiner?					f Death (Check only o	•		
<u> </u>	Attending Physician: r death. ector: After this certific. by the funeral director,	P.	1 ☐ Yes 2 🔯 No		R/Outpatien	1 3LI DOA	- 21	ing Home 5 🗆 Resi			cify)
5	ding P h. After I funera	ion;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injur	y occurred	
200	uttendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	no form str		Yes 2 □ No		Stroat an	d Number or Ru	ral Route Number,
É	or A after Direc In by	Certification;	4 Homicide determined	building, etc. (Specify)	)	set, ractory, onice		City or To			rai noble reamber,
	spite		29a. Certifier 1 ☑ Certifying Phys	sician: To the best of my know	vledge, death	occurred at the t	ime, date and	place, and due to the	cause(s)	and manner as	stated.
	To the Hospitel within 24 hours a Vithin 24 hours and To the Funerel I completely filled	Medical	(Check only 2 Medical Examination)	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my	opinion, death	occurred at the time,	date and	I place, and due	to the cause(s)
	To the Hospitel or Attendin within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	ž	29b. Signature and title of certifier	/		29c. Licen	se number		29d. Dat	te signed (Month	n, Day, Year)
	WA		1/1/				D1533	3		2/17/2	:004
19	7111		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)					
1	<u> </u>		Dr. Thomas John			irth St.	. 0akla	and MD 21	L550		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 8	32. Registrar's Signati		South 9					
	ogioti			The state of the	Je A	The same of the sa					

			1 - State RegistramEND ITEM #16b	State of Maryl PER FH G829 3/	and / Depa /09/04 \$\frac{1}{16}	artment rtificate	of Hea	ilth and eath	Mental Hy	Reg. No		07116
7	Physici		1. Decedent's Name (First, Middle, Last) Mildred Virgini						Feb	28 <sup>Da</sup>	y 2004	7:00P M
. وم	/Medic Examir		4a. Fecility Name (If not institution, give s			4b. City, To	wn, or Loc	ation of Dea	th		. County of Death	
			344 Mountain Vi				berl				llegany	
2	Funeral Director		5. Social Security Number 6. Sex 214-05-8357	וא אסיוב	yrs. last birthday) 90 Yrs.	If Under 1 Months		Under 24 Hr lours Mir	(Month, Di	ev. Yeer	913 Mar	place (State or Foreign ntry) Cyland
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f ahow I.a Musical Exa cite from the rediffed at		10a. State 10b. County		. City, Town or Lo							10d. Inside City Limits
	Ba-fal	Funeral Director	MD Allegan	У	Cumber							1 ☑ Yes 2 □ No
	with th	Dire	10e. Street and Number 344 Mountain Vi	ow Drive		10f. Zip C					tizen of What Cou SA	ntry?
	Jeath The 23	eral		12. Was Decedent Ever	in U.S. 13.			nic Origin? (	Specify Yes or Norto Rican, etc.)		14. Rece - Ameri	
9	or iter	Fur	1 Never Married 2 Married	Armed Forces? 1 GYes 2 ☐ No If Yes, Give	TATTAT	If Yes, specify 1 ☐ Yes 2√		lexican, Pue <i>pecify:</i>	rto Rican, etc.)		Black, White,	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	_II					1 100 11	Specify: Whi	
<u>5</u>	n 72 h	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give	dent's Usual ( kind of work DO NOT use	done durin	n ng most of w	orking	16b. K	ind of Business/In	dustry
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Secr	etary	/Tre	easur	er	<u>_</u>	Retail	
b	al Hyg	BeC	17. Father's Name (First, Middle, Last)					Mother's Na	ime (First, Middle		,	
yla	ould to	ဥ	John I. Vandegr						nces Ma			
Maryland	d 2 sh ih and ih and 7 is rr traurr		19a. Informant's Name/Relationship (Ty) Gayle S. Yost-D								or Town, State, Zip MD 2150	4
	Heal Heal Hem 2	1	20a. Method of Disposition		Db. Place of Dispo	osition (Name	of		Date	<u> </u>	ocation - City or To	
Ë	Pege net o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  *4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Silbaug				March ,2004	Un	iontown	PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avent, if a Michical Examinant by realitied an once.		21. Supreture of Funeral Service License	1111	ŀ		Fune	eral	Service	, P	A	
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failtre. List only or Immediete Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.  Chronic  Due to (or as a cor	Obstru						e, MD 2	Approximate Interval Between Onset and Death
68760,	icate by executed physicien and physicien and sthe burial-transit	edical Examiner	Securalisty is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	ert Fa	ilur	re				5 YS
.O. Box	that the death certifica ed by the ettending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ℚNo 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	∃Ectopic preg ∃ Other (spec					23d. Date of deliv Month	ery Day Year
<u>α</u>	res that igned b be deta	y Pt	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	inderlying cau	se given in	Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
ord	w require been sig should t		Hyperte	nsion					1 🗆	Yes 2	No 3 ☐ Prot	pably 4 □Unknown
Vital Records,	The lar ate has page 2	Completed							24a. Was auto perfe 1 Yes	psy ormed?	prior to co death?	psy findings available impletion of cause of 2 No
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	lospital:					eath (Check only			Assisted
ð	S 0 5	itlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ XNatural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yee	2 ER/Outpatien 28b. Time of Injury		. Injury at Work?	4 □ Nursing	Home 5 ☐ Resi 28d. Describe	idence how inju	6 XOther (Special of the Control of	Living
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st	reet, factory, o	office		28f. Location ( City or To		nd Number or Rura )	al Route Number,
	ha Hospital or in 24 hours afte ha Funeral Dir pletely filled in in	Medical (		sician: To the best of my ner: On the basis of exal and manner stated.								
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	26-11	2//	29c. l	license nu				te signed (Month,	
•	. 0		Deorge Henr	1			שטטט	59479		Ма	rch 1,	2004
	V		30. Name and address of person who co	,			DD	C11-1-	1 2		04555	
	Sta	ate	George Hennawi, 31. Date filed (Month, Day, Year)	32. Registrar's S	gnature			Cumpe	erland,	_MD	21502	
	Regist	rar	MAR 0 9 2	004	14	donate )	79 -					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:45 PM FEBRUARY 18, CELESTA PEARL UPOLE 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUPPETT & WEEKS NURSING HOME OAKLAND GARRETT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 216-38-2043 93 NOV. 19, 1910 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director MD GARRETT MT. LAKE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 H STREET 21550 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ WILLIAM COOK **EMMA** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERMA KEMPHFER - DAUGHTER 2632 MOHICAN DRIVE DOVER, OH 44622 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = 5 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Importent: I any injury o PLEASANT VALLEY CEM. 2/21/04 \* 4 ☐ Donation 5 ☐ Other (Specify) OAKLAND, MARYLAND 21. Sign pare f Funeral Service Licens 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proysician THROMBOCYTOPENIA WEEK resulting in death) /Medical Due to (or as a consequence of) Examiner DEMENTIA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed nding physician and use as the burial-transil Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 X No this After this funeral of 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Direct filled in by 4 Homicide within 24 hours a To the Funerel ( 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H26154 FEBRUARY 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MARYLAND 21550 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2004 9 DHMH 17 Rev 1/2001

Amended Item #1 per physician 02/20/04cs

02/20/04cs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

рı	іуѕіста		1- State of Maryland / Department of Health and Me		ne No. 2004	07110
>	Physici /Medic Examir	cal	4a. Facility Name (It not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Death	Day Year 4c. County of Death	3. Time of Death
	Funeral Director		Usual Residence of Decedent	B. Date of Birth (Month, Day, Ye Feb 10,		ace (State or Foreign
	the Marylan 28a-f show	Director	10a. State         10b. County         10c. City, Town or Location           MD         Garrett         McHenry           10e. Street and Number         10f. Zip Code	100	Citizen of What Countr	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	eath with	Funeral Dir	2364 Mosser Road  21541  11. Marital Status  12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specified Specified S		USA 14. Race - America	
9600	be filed within 72 hours after death with the Maryland stal Hygiene. od other then "natural", or Items 23e or 28a-1 show event, I're Madical Examire must be mailfed at	þ	If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:		Black, White, e	c. :e
21215-0036	filed within 72   Hygiene. other then "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  4 yrs.  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Postmaster		S. Postal	,
Maryland	should be filed withir and Mental Hygiene. s marked other then umatic event, ILE M.	To Be (	17. Father's Name (First, Middle, Last)  Fred Ellsworth Bowser  18. Mother's Name (First, Middle, Last)  Marion Ir	cene Hanr	non	
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  H. Vaughn Vitez/husband  2364 Mosser Rd., McHenr	cy, MD 2	21541	
Baltimore,	Page nent o ant; If ury or		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Zion Cemetery Feb 23, 200	4 Ac	. Location - City or Tow cident, MD	n, State
Ba	permit. Departr Importe eny inje		21. Signature of Funeral Service Licensee  Newman Funeral Miller St., Grant  23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or not enter the mode of dying, such as cardiac or not enter the mode of dying.	sville,	MD 21536	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	esphalory arrest,	t i	oproximate nterval Between on the set and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clasase of injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Hessi	
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month D	ay Year
rds, P.	w requires tha been signed should be del	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
Vital Records,		e Completed	25. Was case referred to medical 26. Place of Death (	24a. Was an autopsy performed 1 Yes 2	prior to comp death?	y findings available letion of cause of
ō	Attending Physicien: r death. ector: After this certific by the funeral director.	ation: To B	examiner?  1	-	6 □Other (Specify) ijury occurred	
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street City or Town, Sta	and Number or Rural F ate)	oute Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and control one)  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	and place, and due to the	e cause(s)
	Twith	-	29b. Signature and title of certifier  Policy Amelian	29d. 0	Date signed (Month, Pa	y, Year)
	Sta	to.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  P. Donnel M. Le Do 69 Wolf Acros  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Drive	auklana	d, MD
	Registr	-	FEB 2 0 2004 May 15 Shorts			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAE WILLIAms **Physician** WILLIE 0310 2004 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY WICOMICO HOSP)TAL LENTER DEERS HEAD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2MF Days S.Carolina Director 248-40-4498 Dec.3 1926 Usual Residence of Decedent filad within 72 hours after death with tha Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County h and Mental Hygiane. 7 is marked other than "naturel", or Itams 23e or 28e-1 show treumetic event, the Mcdical Examiner must be notified at 1 ☐ Yes 2 📉 No Directo Maryland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1106 Tuscola Avenue U.S.A 21801 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 I No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Domestic None 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 end 2 should be fili ment of Health and Mental H lant: if item 27 is markad oth Jury or othar treumatic aven Be Elise Davis Kimory Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lorrie Scot (Granddaughter) 2309 Elliott Ave. Apt. 3B Portmouth Va 23702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 123/04 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of important: If it any Injury or conce. 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Md. 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee Hlady B. Stewart 821 West Rd.Salisbury, Md

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 821 West Rd.Salisbury, Md.21801 Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) SEPSIS /Medical 2 WKS Examiner Due to (or es a consequence of) VASCULAR INSUFFICERCY Examiner KERIPHERAL or Attanding Physicien: The law raquires that the death certificate be axecuted Due to (or as a consequence of): and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MELLITUS-TYPEZ ata has baan signad by tha attending physician page 2 should ba detachad for usa as tha bunal DIABETES Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events Due to (or as e consequence of): resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown NEPHROPATHY, DIEBETIC þ CONGESTIVE HEART FAILURE 24b. Were autopsy findings Completed 24a. Was en autopsy performed? available prior to completion of cause of death? CARDIC MYOPATHY 2 🛛 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death

1 X Natural

2 ☐ Accident 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Funaret Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours to the Funarel L Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier ulary MD CMD 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) POPOXZOIS SALISBURY MOZI802 Dulany MD CMD VERGINIA A

32. Registrer's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB 19

2004

		•	For State Registrar	State of I	Marylan		artment of I				ene <sub>э. No</sub> 2 0 (	) 4	07120
	Physici		1. Decedent's Name (First, Middle, L. Bernice Fay		eicht					Date of Death Month Druary	18, 20	704	3. Time of Death 9:30 A M
*	/Medic Examin		4e. Facility Name (If not institution, gi				4b. City, Town, Reiste				4c. County o		2
	Funeral Director		5. Social Security Number 6.	Sex 7. 1 ☐ M 2]X] F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Dey, une 16	Year)		lace (State or Foreign
	aryland show	,	Usual Residence of Decedent  10a. State 10b. County  MD Baltime	270		, Town or Lo						1	0d. Inside City Limits 1 X Yes 2  No
	ith the M or 28a-f	Directo	10e. Street and Number		I I I I		10f. Zip Code			10	g. Citizen of W	hat Cour	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	204 Cork Ln  11. Marital Status  1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X No		21136 Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Ori pan, Mexican	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	USA 14. Race Black Specify:	, White,	etc.
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, Maryland	1 and 2 should Health and Men Iem 27 Is marke		19a. Informant's Name/Relationship Glenda Weicht			3	ng Address <i>(Stree</i> Cork Ln	t and Numbe	or Or Rural Ro	oute Number,			Code)
altimore,	Pages 1 annual of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Spec			emetery, crei	esition (Name of matory or other pla Cemetery	, 1	Date 21 2	1.	oc. Location - C	•	
Balt	permit. Departr Importe any inji		21. Signature of Fyneral Service Lice	Bude	ock	I	Name and Addr David A. 710 Churc	Burdo	ck FH	iller,	MD 21	538	
	Physician		23a. Part Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that cau y one cause on each	sed the death	n. Do not ent		-	cardiac or re		st,		Approximate Interval Between Onset and Death
o,	Medical Examine physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cor Due to (or	as a consequence as a c	Jence of):	ertery	di	Alax	L_			
P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnand	by .			23d. Date Mont		ry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions Alzheime		h but not resu	•	nderlying cause gi	ven in Part I.					e cause of death? ably 4 Dunknown
al Reco	: The law recate has bee	Completed								24e. Was an autopsy perform	ed? pri	or to con ath?	osy findings available inpletion of cause of
Division of Vital Records,	ding Physician: The h. h. After this certificate ha funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			ER/Outpatier 28b. Time o Injury	28c. Inju	her: 4 🗆 Nu	rsing Home 28d.	-/-3	ce 6  Other	(/	)
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined	28e. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office			Location (Stre City or Town,		or Rura	Route Number,
	he Hospit in 24 hours the Funers pletely fille	Medical (	(Check only 2   Medicel Exa	hysician: To the be miner: On the basi and manner	s of examinal	wiedge, deati tion and/or in	n occurred at the t vestigation, in my	me, date and opinion, deat	d place, and th occurred a	due to the cau t the time, dat	ise(s) and mani e and place, an	ner as st d due to	ated. the cause(s)
	To To To To To To To To To To To To To T	Σ	/ /	elsman			29c. Licen				d. Date signed (		
	32		30. Name and address of person who	MAN . M	1.0,	1205	Print) York R	oad, S	suite	38,L	whervi	lle,	18,2004. MD21093
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 0	2004 P	istrar's Signa	ture	Rosell a						

			1 - For State Registrar	State of M	larylan			t of Hea e of De			Reg. N	7 H H L	. 07	121
1	Physici	an	Decedent's Name (First, Middle, I     WILLIAM	JAMES		ZIEGLE	ZR			2. Date of Month	Da	y Yee		e of Death
1	/Medic		4a. Fecility Name (If not institution, g		)	212021		Town, or Loc	cation of Death	1-chru		c. County of De	eath	70
18	Examir	ier	PONINSULA Region	1 11	1 1	oster		340	ISSUM			1/10	omice	<b>S</b>
Г	Funeral			OV□M 2□E	-	last birthday)	If Under Months		Under 24 Hrs. lours Min.		Day, Year		lirthplace (Sta Country)	
h	Director		548-36-9859 Usual Residence of Decedent		33	Yrs.				March	4,19	20 M	aryland	3
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							e City Limits
	e Mar 3a-1 s	ctor	Maryland Wicom	ico		Salisbu	<del></del>							′es 2 🙀 No
	with th	Director	10e. Street and Number				10f. Zip					itizen of What	Country?	
	eath ne 23,	Funeral	27320 Independ	12. Was Deceden	t Ever in U.	.S. 13. V		21801 dent of Hispa	anic Origin? (S Mexican, Puerl	pecify Yes or		ISA 14. Race - Ar	nerican Indiar	1,
9	s within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28a-1 show the Medical Examiner must be notified at	Fun	1 ☐ Never Ma <i>m</i> ied 2 ☐ Married	Armed Forces 1 12 Yes 2 11 Yes, Give	? <sup>] N</sup> Armv	7/	fYes,spec I□Yes 2		Mexican, Puert <i>Specify:</i>	o Rican, etc.)		Black, Wi		
21215-0036	ural',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates	AirCo	rp					10		white	
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212	d within jiene. r than	omb	Elementary/Secondary (0-12)	College (1-4or	5+)	Produ	ace D	irecto	or		0	rocery	Store	
	be filed tal Hygid d other event, I	BeC	17. Father's Name (First, Middle, La	st)				18	. Mother's Nan	ne (First, Mide	dle, Maide	n Sumame)		
yla		2	Samuel Ziegle					12.		Lawren		T . C	T- 0- /-)	
Maryland	and and is rr		19a. Informant's Name/Relationship Linda L. Ziegler		in-la		-					or Town, State		01
	s 1 and 2 f Health item 27 other tr	183	20a. Method of Disposition		20b. P	Place of Dispo emetery, cren	sition (Nan	ne of	1	Date	-	ocation - City		
E	0 0 = 2		1 X Burial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe		9	yland Ve			exy $2/2$	24/04	Hu	rlock,	MD	
Baltimore,	permit. Peg Department important: any injury c		21. Signature of Funeral Service Lit		- 0	22	Name an	nd Address o	f Facility	Home P	rofes	sional	Associ	ation
=	20519		23a. Pert1. Enter the disease, or co	undy (f.	P		501 S	now H	LLL Rd.	, Sali	sbury	, MD 2	1804 Approxi	
H			shock, or heart failure. List or Immediate Cause (Final	ily one cause on each	line.	$\overline{\Omega}$				or respirator	y arrest,		Interval Onset a	Between nd Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	s a conseq		EUM	ONCI	A			·	<2	.У
P	Examiner		Sequentially list conditions,	b										
( A.)	sit ad	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conse	uence of:								
	te be executed ysicien and ne burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):							1	
760,	ite be e iysicier ne buria	calE		d				\						
68			IF FEMALE:	1152					-				İ	
Вох	death certifica e attending ph id for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	I death 3	Ectopic pr					23d. Date of o	delivery Day	Year
0	thet the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	eath 5∟	Other (sp	өсіту)			_			
Δ.	s thet ned by	by Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the ur	nderlying ca	-	10.00		id tobacco	use contribute	to the cause	of death?
ords	w requires been sign should be	edb	LEF	f Pheun	ONECT	romy	TOR	LLL	US CAN	TER 1	☐ Yes 2	3 □	Probably 4	□Unknown
Records,	2 5 0	Completed								24a. W	topsy	24b. Were	autopsy findir o completion	ngs available of cause of
al R										1 ☐ Ye	nfórmed? s 2€4	o 1 Y	es 2 No	
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?  Yes 2 □ No	Hospital:	a 🗆	ER/Outpatien	nt 3 DO	Other	5. Place of Dea			C □Other (C	22241	
of		I	27. Manner of Death	28a. Date of In	jury	28b. Time of		8c. Injury at Work?				6 □Other (S)	Decity)	
ion	Attending I or death. ector: After by the funer	atlo	2 Accident 5 Pending investiga	tion	ay (661)	Injury	М		2 🗆 No					
Division	or Attendated death Director: in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of I	njury - At he etc. (Specif	ome, farm, str fy)	eet, factory	y, office			n (Street a Town, Sta	and Number or te)	Rural Route f	lumber,
	To the Hospitel or At within 24 hours after or to the Funeral Directompletely filled in by		29a, Certifier Sertifying	Physicien: To the bes	at of my kno	wledge death	occurred	at the time.	date and place	and due to t	he cause(	s) and manner	as stated.	
	e Hos 24 ho e Fun letely	Medical		caminer: On the basis and manner:	of examina									se(s)
	To th within To th comp	Me	29b. Signature and title of certifier	71				c. License nu			29d. D	ate signed (Mo	nth, Dey, Yea	r)
			> Relet.	my				D36	576		7	20/04		
VA	ľ		30. Name and address of person w	ho completed cause of		n 23a) (Туре,	Print)	RIV	ERSIC	E DE	S	HL15150	RY M	0815 C
	St	ate	31. Date filed (Month, Day, Year)		trar's Signa			1	,					
	Regist	rar	FEB23	2004	exercia		24	UURA						

NAME KNOWN TO PHYSICIAN: CLERYL BILL ASH BRItimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

	1- For State of Maryland	/ Department of Health and I Certificate of Death	Mental Hygiene
Physician	Decedent's Name (First, Middle, Last)	¥	2. Date of Death Month Day MARCH 6, 2004  3. Time of Death 10:50P M
/Medical Examiner	CLERYL BILL ASH, SR.  4a. Facility Name (If not institution, give street and number)  VA MARYLAND HEALTH CARE SYSTEM	4b. City, Town, or Location of Death PERRY POINT	
Funeral Director	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. la:</i> 1236–44–5678		8. Date of Birth (Month, Day, Year)  Jan. 21, 1930  9. Birthplace (State or Foreign Country)  W. Virginia
or 28a-f show be notified at		Town or Location  Joppa  10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2元秋o  10g. Citizen of What Country?
or items 23a	10.3 Fern Drive  11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S Armed Forces? 12. Was Decedent Ever in U.S Armed Forces? 12. Was Decedent Ever in U.S Armed Forces?	If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
ed within 72 hours ygiene. Isr than "neturel", t, the Wedfall Ex.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12	16a. Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retired)  Foreman	16b. Kind of Business/Industry
I be filed nital Hyge ed othe sevent,	17. Father's Name (First, Middle, Last)	18. Mother's Nar Mildred	ne (First, Middle, Maiden Sumame)  Helen Montgomery
d 2 should the and Men 7 is marke traumatic	Homer (nmn) Asn  19a. Informant's Name/Relationship (Type, Print)  Janice Ash-Henry - Daughter		iral Route Number, City or Town, State, Zip Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Importent: If item 27 is marked other than eny injury or other traumatic event, In Menons.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Disposition (Name of metery, crematory or other place)	Date 20c. Location - City or Town, State 10/04 Baltimore, Maryland
permit. F Departm Importer eny injur	21. Signature of uneral Service Licensee	22. Name and Address of Facility Mc	Comas Funeral Home, P.A. , Abingdon, MD 21009
cate be executed Cate b		COLON CANCER ence of):	c or respiratory arrest, Approximate Interval Between Onset and Death UNKNOWN
attending p for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Feal 4 ☐ Pregnant at time of de	death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
wrequires that the diplement is should be detached in the should be detached in the should by the should be detached in the should be detached in the should be detached in the should be	Part II. Other significant conditions contributing to death but not result	lting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Munknown
The law requir			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No   24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Physician: rthis certific ral director,	25. Was case referred to medical examiner?	Other	ath <i>(Check only one)</i> tome 5 ☐ Residence 6 ☐ Other <i>(Specify)</i>
or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page		28b. Time of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After tompletely filled in by the funerel Director.	3 Suicide 6 Could not be determined 28e. Place of Injury - At hon building, etc. (Specify,	me, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel or within 24 hours after To the Funerel Director Completely filled in Director C		ion and/or investigation, in my opinion, death occ	urred at the time, date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	29c. License number D20215	29d. Date signed (Month, Day, Year)  MARCH 6, 2004
12+1	30. Name and address of person who completed cause of death (Item KARMACHANDRA NAIR, M.D., VA MAR	YLAND HEALTH CARE SYST	EM, PERRY POINT, MARYLAND 2190
State Registra	SECTION OF COURT ENGINEERS A SER	Apole .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State of	Marylar	nd / Depa	artment rtificate				ental Hy	Reg. N	2004	
	Physicia /Medic	an al	1. Decedent's Name (First, Mid Carol)		G.	L-3	Aiu	stin	Tour or	Location o	1	Month March	3,	2004 C. County of Death	3. Time of Death 6:20 P M
	Examin		4a. Facility Name (If not institute Charleston  5. Social Security Number	Care 6. Sex	Cen	iter 7. Age (In yrs.	last birthday)	Cat	Onsv	ille IfUnder:	24 Hrs.   8	. Date of Bi	rth	Baltimon	
	Funeral Director		224-16-2806  Usual Residence of Decedent  10a. State 10b. Coun	<u> </u>	# 2 <b>K</b> 1F	87	Yrs.	Months	Days	Hours	Min.	(Month, De )ec. 2	ау, төаг 5 <b>.</b> .		nsylvania  10d. Inside City Limits
	th the Maryla or 28a-1 show	irector		imore	Iana	100. 01	Caton		Code	1 2 2 0			_	itizen of What Co	1 TYPes 2 □ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important if item 27 is marked other than "natural", and once.	by Funeral Director	11. Marital Status  1 Never Married 2 M. 3 XWidowed 4 Divorce	12		2 □ <b>X</b> No 9		Was Deced If Yes, spec 1 ☐ Yes 2	ent of His	1228 spanic Origin, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No can, etc.)		14. Race - Amer Black, White Specify:	
21215-0036	id within 72 hou giene. er then "nature , tre Medicel E	Completed	15. Deced (Specify only high Elementary/Secondary (0-12 12	est grade		4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d e retired)	uring mosi			Pri	ard Of Ed	ges County
Maryland	nould be file d Mental Hy narked othe natic event,	To Be C	17. Father's Name (First, Middle Fred  19a. Informant's Name/Relatio		Geis		19h Maili	na Address	(Street a	Min	elua			n Surname) WOC	
	s 1 and 2 sh Health and tem 27 is n other traun		John Austin/ 20a. Method of Disposition	Son		1		haron osition (Nan	Driv	ve, B	oyce,	Virg:	inia	22620	Town, State
Baltimore,	permit. Pages Department of Important: if i any injury or once.		1 ☐ Burial 2 🏋 Crematio 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service	(Specify)		state	ntt Cr	emato:	ry		3/10/ <sup>v</sup> Robe			ldorf, M	
Ä	Department Department		23a. Part1. Enter the disease, shock, or heart failure. L	or complications	ations that can be cause on ea	ach line.	th. Do not en	6000 A	Annaj e of dying	olis , such as	Road cardiac or	, Bow	ie,	Maryland	20715 Approximate Interval Between Onset and Death
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	( a.	Due to (	or as a conse			rt.	Faile	cre				months months
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d.		or as a conse									
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23	1 Live bi	come of pregr irth 2 Fet ant at time of own	al déath 3[	□Ectopic pr □ Other (sp						23d. Date of deli Month	very Day Year
<u>α</u>	quires that t n signed by uld be deta	ğ	Part II. Other significant cond	tions cont	ributing to de	eath but not re	sulting in the u	ınderlying c	ause give	on in Part I		1			the cause of death?
l Reco	The ate h page	Completed								<del>.</del> .		24a. Was auto perf 1 Yes		prior to death?	topsy findings available completion of cause of
n of Vital Records,	Physician: this certific ral director,	To Be	25. Was case referred to med examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pen	Н		npatient 2 [ of Injury h, Day Year)	ER/Outpatie	of 2	8c. Injury Work	at	ursing Hom		idence	6 □Other (Specury occurred	ify)
Division	or Attene	Certification:	2 Accident inve	stigation		of Injury - At I	nome, farm, st	reet, factory		/es 2□		3f. Location City or To	(Street a	and Number or Ru te)	ral Route Number,
	ne Hospital n 24 hours a ne Funeral I	Medical C	29a. Certifier 12 Certifier (Check only one)	ying Physi al Examin	er: On the ba	best of my kr asis of examin ner stated.	nowledge, dea nation and/or in	vestigation	, in my op	oinion, dea	nd place, an	nd due to the	, date a	s) and manner as nd place, and due	to the cause(s)
	7	W	29b. Signature and title of cert	4	MD			D 290	License	number 447			29d. D	ate signed (Month	), Day, Year) 2004
	10		30. Name and address of pers	1.5	211	200 11	m 23a) (Type	Print)	Q	Lan	و ر	aton	SV	inch 4 7	ryus
	St Regist	ate rar	31. Date filed (Month, Day, Ye	o 9 20	)04 J	egistrans Sign	nature	fred	1						

		-	For State Registrar	State of Mar	yland / D	epartment of F Certificate of	lealth a Death		Reg. No	200	- 1 L. 7
ı	Physicia	ın	1. Decedent's Name (First, Middle, Last)	00				Mon	of Death th Da RCUL 3	y Yeer 2004	3. Time of Death
>	/Medic Examin		JEAN W. BAYLO 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location			County of Dee	
			34(1)	ALTH CAR		BAU				NA	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (	In yrs. last birtl Y	nday) If Under 1 Year Months Days	If Under Hours	Min. 8. Date (Mor	of Birth oth, Day, Year 28 - 1913	2   C	thplece (State or Foreign ountry)
	/land		10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	a-feh	ctor	MO NA		BALTIN	NORE					1 🔀 Yes 2 🗌 No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	leath v	Funeral Director	3300 ALTO ROAD	12. Was Decedent Ev	er in U.S.	2/2 13. Was Decedent of H	lispanic Ori	igin? (Specify Yes	or No-	14. Race - Am	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examination until be multilled at 2008.	ρ	1 Never Married 2 Married 3 WWidowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 💆 No	an, Mexicar Specify:	n, Puerto Rican, e	tc.)	Black, Whi	te, etc. ACK
- 2	72 hou	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Decedent's Usual Occup (Give kind of work done	during mos	at of working	16b. I	Kind of Business	/Industry
21215-0036	od within giene. er then.	Completed	Elementary/Secondary (0-12) 8 TH GRADE	College (1-4or 5+)		HOME MAK				Domes	ПС
nd	be filed stat Hygid od other event, I	Be	17. Father's Name (First, Middle, Last)					er's Name (First, I		n Sumame)	
Maryland	thould id Mer marke matic	은	HURLEY WHALEY  19a, Informant's Name/Relationship (Ty.	pe. Print)	19b.	Mailing Address (Street		E JON er or Rural Route		or Town, State,	Zip Code)
	aith ar aith ar 27 is ar trau		CARLOTTA VAUGHA		34	80 HILLSME	RER	D. BALT	om o	21207	
ore,	es 1 a of He of He of item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	20b. Place of cemetery	Disposition (Name of crematory or other plan	сө)	Date	20c. l	ocation - City or	Town, Slate
Baltimore,	t. Pages tment of tant: If it njury or o		* 4 □ Donation 5 □ Other (Specify)	~	BALTO.	Property and the second		3-10-04		LTO. MD	
Bal	Depa Impo eny it		21. Signature of Funeral Service Licentary	<u> </u>		VAUGHN C. 551 BAHO.	NATL	PIKE B	1110. M	SERVICE MO 212	29
*			23a. Part1. Enter the disease, or complishock, or hear failure. List only or	ications that caused the ne cause on each line.	ne death. Don	ot enter the mode of dyli	ng, such as	cardiac or respira	itory arrest,		Approximate Interval Between Onset and Death
10	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	SEPS						DAMS
	Examiner		f .	Due to (or as a t	consequence c	,,					
	po tis	Iner	Sequentially list conditions, y to a modern to the cause. Enter Underlying Cause (Disease or injury	Due to for as a	cons « uence c	f):					
	xecute and	Examlner	that initiated events resulting in death) Last	Due to (or as a c	consequence o	f):					
58760,	icate be executed physicien and s the burial-transit	dical		j							
		-	IF FEMALE:	3c. If yes, outcome of	pregnancy					and Date of de	li an
P.O. Box	the death certify the attending sched for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		_	23d. Date of de Month	Day Year
	es that igned b	by	Part II. Other significant conditions con DEHYDRATIC	,	not resulting in	the underlying cause given	ven in Part I	I. 23e	Did tobacco		o the cause of death?
Records,	φ <u>τ</u> <u>Θ</u>	Completed	HYPERNATRE	MIA					. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
tal	ifcien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place	1 □ e of Death (Check	Yes 2 N	o 1 Yes	s 2 No
Ž	S =	To B	examiner? 1 □ Yes 2 No	lospital: 1 Inpatient		patient 3 DOA		ursing Home 5[			ecify)
o uoi	ding F. After fune	atlon:	27. Manner of Death  1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )	/ea <i>r)</i> 28b. T	ijury Wo	ryat rk? ]Yes 2□		scribe how inj	ury occurred	
Division of Vital	of or Attendiater death after death Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, far (Specify)	m, street, factory, office	2 1 2 2 2		ation (Street a or Town, Sta		ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	ledical C			xamination and	, death occurred at the to for investigation, in my of					
	vithin 2 To the Complet	Me	29b. Signature and title of certifier		1	29c. Licens				ate signed (Mon	th, Day, Year)
	10		N 9 8	PHYSICI	M	PI	563	53	MAT	2CH 3	2004
	O		30. Name and address of person who or LAURA KHAINDIAC	ale 900	CAT	Type, Print)  TON AVE/	ME	BALT	mon	5 MAR	YLAND 21229
9	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 9 2004	32. Registrar		baste					

DHMH 17 Rev 1/2001

NAME & JEAN BAYLOR

				State of Maryland / Department			-	_	
			For State Registrar		tificate of Dea		Reg. N	2001	07129
			Decedent's Name (First, Middle, Last)				ite of Death		3. Time of Death
	Physici /Medic		James R	.•	Beasley, Si			2004	11:30 p <sup>M</sup>
7	Examin		4a. Facility Name (If not institution, give stre	et and number)	4b. City, Town, or Loca		4	c. County of Death	
			47 Cinder Rd.		Luthery		I Diet	Baltimor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		ours Min. (Me	te of Birth onth, Day, Year		place (State or Foreign ntry)
	Director		212-05-2436 X	89 Hs.		Jai	n. 2	1915 MD	
	/land		10a. State 10b. County	10c. City, Town or Lo	cation			1	Od. Inside City Limits
	Man a-f sh ifted	ţō	MD Baltimor	re Luthery	ville				1 Yes 2 No
	or 284	Funeral Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cour	ntry?
	23a	ral	47 Cinder Rd.		21093			USA	1.4
	er deg	nue	11. Marian Glatas	Was Decedent Ever in U.S. Armed Forces?  1 ▼Yes 2 □ No	Was Decedent of Hispan If Yes, specify Cuban, Mo	exican, Puerto Rican,	es or No- etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWII	1⊡Yes 2 <b>x</b> No <i>Sp</i>	pecify:		Specify: W	hite
5-0036	72 hours after death with the Maryland natural; or Hems 23a or 28a-f show dical Examinar must be motified at	ted	15. Decedent's Educat		dent's Usual Occupation kind of work done during	a most of working	16b.	Kind of Business/In	dustry
215	within 7. ene. then "n	ple	(Specify only highest grade c	College (1-4or 5+)	DO NOT use retired)	g most or working			
2	gient gient er th	Completed		2 Insur	ance Inves			nsurance	
pu	d oth	Be	17. Father's Name (First, Middle, Last)	Decelor		Mother's Name (First		n Sumame)	
yla	should be filed within nd Mental Hygiene. marked other than imatic avant, the Mental control of the Mental con	2	Hewett Anderson		ng Address (Street and N	Florence D	00	or Tour State 7in	Code
Maryland	12 sho h and 7 ie m traum		19a. Informant's Name/Relationship (Type						
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or litems 23a or 28a-f show or other traumatic avent. The Medical Examinar must be notified at		James Ross Beasley 20a. Method of Disposition	20b. Place of Dispo	S. River La	Date		Location - City or To	
0	ages ont of it; if it	1	1 Surial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State	matory or other place)  Valley Men	ndrial Card	dens Ti	monium	MD 21093
Baltimore,	permit. Pages Department of Important; If if any injury or o		21. Signature of Funeral Solvice Lice isee						
Ba	Depariment of the population o		Michael J. Fled		2. Name and Address of emmon Fune 0 W. Padon	eral Home ia Rd T	of Dula imonium	ney Valle . MD 21	ey, Inc. 193
	WE I		23a. Part Ent the disease, of comp. ca shock, or heart failure. List of your	tions that caused the death. Do not en	ter the mode of dying, su	ich as cardiac or resp	iratory arrest,		Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition	Motosta	Atie Or	Anak	11-		Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequence of):	1.0	1100			
В	Examiner	Ļ	Sequentially list conditions, b.	0					
<u></u>	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
	be executed sicien and burial-transit	хап	that initiated events c resulting in death) Last	Due to (or as a consequence of):					
09	eath certificate be exattending physicien for use as the buria	ल							
687	certificate nding phys	Physician/Medic	U						
Вох	anding use	N/U	23b. was decedent pregnant	If yes, outcome of pregnancy	☐Ectopic pregnancy			23d. Date of deliv	,
_ •	D 0 D	lcla	in the past 12 months? 1 □ Yes 2 □ No		Other (specify)			Month	Day Year
P.0	that the dended by the a	hys	9 Unknown		210 77 77 7		O- Did tabasa		ha naves of death?
	9 0 0	b	Part II. Other significant conditions contri	buting to death but not resulting in the L	inderlying cause given in	1 Рап I. 2	_ •	use contribute to t	
ord	w requir been si should	Completed							
ec	law has b	npie					4a. Was an autopsy performed?	prior to co	opsy findings available empletion of cause of
H H	: The la cate has	S					Yes 2		2( No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:	Othon	. Place of Death (Che		s 🗆 Orber (Green)	4.1
of Vital Records,	Phys r this ral di	. To	1 Yes 2 No	28a. Date of Injury 28b. Time of	III 3LI DOA	4 Nursing Home 28d. D	Describe how inj	6 ☐Other (Special ury occurred	ry)
on	ding F th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		2 🗆 No			
Division	Attending Physician: r death. sctor: After this certifics by the funeral director, i	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		ocation (Street a	and Number or Run	al Route Number,
Ö	el or A s after el Direct	Certification;	4   Homicide	building, etc. (Specify)			ny 01 10mm, 012		
	To the Hospitel or Attent within 24 hours after death To the Eunerel Director: completely filled in by the			cian: To the best of my knowledge, dea or: On the basis of examination and/or in					
	To the H within 24 To the F complete	Medical	one)	and manner stated.	29c. License nui			ate signed (Month)	
	5 3 5 8	-	29b. Signature and title of certifier	0 100	1)20	402		3/5/	21
	1		5 Jollin	70 (11/1)	1759	U		1 0/0	4
	10		Dr. Robert Gattuso,			on, MD 211	11 Unit	20/B	
	St	ate	31. Date filed (Month, Day Year) MAR 0 9 2004	32. Registrar's Signature	M.	one FID ZII	TT OHILL	_4V <del>1</del> D	
	Regist		MAK U 9 2004	Willes Is the					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ruth Т. Bigley 9:05 AM March 2004 /Medical 4b. City, Town, or Location of Death 4a Facility Name (ff not institution, give street and number) 4c. County of Death Examiner 5605 Vancouver Court Churchton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Yrs. Director 209-18-9137 1926 Pennsylvania Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Anne Arundel Churchton Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours efter death with to nent of Health and Mental Hygiene. Int: If Item 27 Ia marked other than "natural", or fleme 23a or: 5605 Vancouver 20733 Court U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Kay Jewelers 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Car1 Butkus Petronella Galkauskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as important: If from 27 is any injury or other trau John C. Bigley/ Son 5605 Vancouver Court, Churchton, Maryland 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Crownsville, 20a. Method of Disposition 3/107 cametery, cremetory or other place)
Maryland Veterans
Cemetery ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner use es the buriel-transit Attending Physician: The lew requires that the death certificate be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) ettending physician end I for use es the buriel-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detected 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? has this certificate 1 Yes 2 XNU 1 ☐ Yes 2 ☐ No efter death.

Director: After this certific d in by the funerel director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2₺ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4□ Nursing Home 5 AResidence 6 □Other (Specify) 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò within 24 hours e To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) 8 2004 0032 47 00000

Registrar

State

ORIGINAL

501 North Frederick Avenue,

32. Registrar's Signature

Gaithersburg, Maryland

20877

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Leszek Karowiec, MD

MAR 0 9 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:35 DM **Physician** Cecelia Mary Benesch March 2000 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ASt. Agnes Hospital Baltimore Il Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 216-03-1044 1 ☐ M 2 💢 F 84 Director Jan. 4, 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State rai', or Itama 23a or 28a-f show Examiner must be notified at N/A Baltimore 1 XYes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 3039 Mallview Rd. U. S. A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify. 3√ Widowed 4 Divorced Completed by "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be it of Health and Menta Leo Pope Vivian Artenias 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Benesch, daughter 3039 Mallview Road Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Glen Haven Cemetery | 03-11-04 Glen Burnie, MD ♣☐Donation 5 ☐ Other (Specify) 1. Sign ware at Funeral Service Licens 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septic Shock Clay S **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** failure ·na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the death certificate be executed Coagulo Dath that initiated events resulting in death) Last the attending physician and Due to (br as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year detached for 5 Other (specify) 1 ☐ Yes 2 No o 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has certificate 1 ☐ Yes 2 No Vital Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To this ō 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 5 Pending 1 Natural 2 Accident 1 Yes 2 No investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and the of certifier 29c. License number africes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD, 215 H. James de 900 Carton 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

DHMH 17 Rev 1/2001

ENESC

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Angeline Backof MARCH 5. 2004 4:05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days 1 M 2XXF 76 Maryland Director 217-20-5270 Aug. 27, 1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or itams 23s or 28s-f show any injury or other traumatic event. Its Medical Examiner is used the notified at once. My Yes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21206 110 Chesley Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Pepka Stephen P. Α. Figiel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 / Daughter 3805 Overlea Avenue Baltimore, Maryland Joanne E. Backof 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/8/2004 Baltimore, MD Parkwood Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Signature of Funeral Service Michael E. Canapp Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician BILATERAL PNEUMONIA DAYS /Medical Due to (or as a consequence of): Examiner MYOCLONUS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed RECENT LUMBAR VERTEBROPLASTY peen 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? 1 ☐ Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation s after decral Director: After M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D 25886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND IA CEBAL D LOS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 07129 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Byrne **Physician** 6:18 Gloria March 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Hospital N/A Harbor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔼 F Yrs. West Virginia 217-32-9061 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Baltimore Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 USA 104 6th Avenue filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) at Hygiene. Bar 12 Hostess 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9058. 17. Father's Name (First, Middle, Last) Be Liela Α. Willis Charles Rites 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 104 6th Avenue, Baltimore, MD 21225 (Son) Barry J. Byrne\_ Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 3/10/04 Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final Infarct - Acute Myocardial immediate **Physician** resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Indexing Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetel death 4☐Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month detached for 5 Other (specify) Yes 2 No P.O. 9 Unknown ά Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27 Manner of Death al or Attending Plater death. Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a pellil 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier H0051791 2.0. amara o 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)
Tamara L. Kile, D.O. 3001 South Hansver Street Boutimore MD 21225 Tamara L. Kile, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR 0 9 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 12:10 **Physician** 2004 March onn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Bayview Medical Center Baltimore Johns Hopkins
5. Social Security Number N/A If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. Date of Birth (Month, Day, Year)
June 3,1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1₽M 2□F Maryland 85 Director 216-09-2492 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 21 ☐ No Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itams 23a or United States 21220 1305 Washington Irving Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or ita, any injury or other traumatic event, the Medical Exertime Amed Polces! 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Industry Steel Worker 9 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virginia Slack Joseph Bena ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 1305 Washington Irving Lane Baltimore, MD Wife Eloise Bena 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/8/2004 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 while Approximate Interval Between Onset and Death rt1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. shock, or heart failu Immediate Cause (Findisease or condition resulting in death) Physician Due (or as a consequence of): days /Medical **Examiner** eritanitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed neumonia and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Iract Physician/Medical rinary IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 should be 1XYes 2□No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed2 2 X No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the f within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Res-000 Dr. Christine Lee March 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins BMC, 4940 Eastern Avenue, Baltimore, MD Dr. Christine Lee 31 Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 9 2004 Registrar

	_=		1- For State Registrar	State of Maryland / Do	ера		Health and	Mental Hy		e 2nn	
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last Gary  4a. Facility Name (If not institution, give			B/im/	in &	2. Date of De Month	h -	Year 6 200 Lc. County of Dea	7:13 M
		iei	Johns Hopkins Bayviev 5. Social Security Number 6. Se	Medical Center	day)		If Under 24 Hr			N/A	
***************************************	Funeral Director		·	<b>X</b> M 2□ F 44 Yr		Months Days	Hours Mir		y, Yea 5 , 19	959 M	rthplace (State or Foreign ountry) aryland
d 21215-0036	Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the rectified at once.	Director	10a. State         10b. County           Maryland         Bal           10e. Street and Number	10c. City, Town o	or Lo		unda1k		10a. C	Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2€5€No
, t	2 2 3 a o		2616 Ambler Ro				21222			Inited S	
<b>U36</b>	al', or Items	by Funerai	11. Marital Status  **EXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cub: 1 ☐ Yes 2 1 No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	•	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	e. an *natur Medical	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (0	Give	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b.	Kind of Business	
7	ygien her th		12 Years	30/10g6 (1 40/ 54)	D	isabled				N/A	
	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		n Sumame)	
Mary	th and Me 7 is mark traumatic	To	Henry Ormand Blin  19a. Informant's Name/Relationship (Ty  Mrs. Mary Blimli:	rpe, Print) 19b. N	Mailin	g Address (Street	and Number or R	ry Kimbal Bural Route Numbe undalk, M	r, City	or Town, State,	Zip Code) 1222
ore, I	t of Healt If Item 2 or other		20a. Method of Disposition 1 ☐ Burial   \$\frac{1}{3}\text{Cremation} 3 ☐ F	20b. Place of D	ispo			Date Date		ocation - City or	
baltimore,	Departmen Important: any injury once.		*4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Strice Licens	// Hżlltc	, .	Service Name and Addres Ouda-Ruck		/9/2004 L Home of		•	Maryland Inc.
188.		-	23a. Part1. Enter the disease, or complete shock or heart failure. List only or	ications that caused the death. Do not	- 7	'922 Wise	Ave. D	undalk.	Mar	yland 2	1222 Approximate
	hysician Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):		,					Interval Between Onset and Death
E	xaminer	ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):						į	
or ou,	hysician and the burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
the death certifical	by the attending phy: tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			Ectopic pregnancy Other (specify)				23d. Date of deli	ivery Day Year
quires that	s been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting in th	e un	derlying cause give	en in Part I.				the cause of death?
ician: The faw requires that the		Completed						24a. Was a autops perforr	y ned?	prior to death?	topsy findings available completion of cause of
Physician:	is certific director,	Be	25. Was case referred to medical examiner?	ospital:				ath (Check only on			20 140
ding Phys	SE D	tion: To	27. Manner of Death 1 Katural 5 Pending	1 ★ Inpatient 2 ☐ ER/Outpat  28a. Date of Injury (Month, Day Year)  28b. Time Injury	e of	28c. Injury Work	4 Linursing F	lome 5 Reside			eify)
at or Attending	s after deal	Sertification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	stre		63 2 110	28f. Location (St City or Town	reet an n, State	nd Number or Ru )	ral Route Number,
he Hospita	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funera	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	eath r inve	occurred at the timestigation, in my op	e, date and place inion, death occu	n, and due to the ca arred at the time, da	ause(s) ate and	and manner as I place, and due	stated. to the cause(s)
Tot	To t	W	29b. Signature and title of certifier	Parell		29c. License	5 - 000			te signed (Month	6, 2004
	5		30. Name and address of person who compress ANAND PAREEH, JOHNS	npleted cause of death (Item 23a) (Typ HUFFINS BAYVIEW MEDIC			EASTELN AV	EME BALTI	MORE	MARVIN	ND 21224.
	Stat	e	31. Date filed (Month, Day, Year) MAR () 9 2004	32. Registrar's Signature				, , , , , , , ,	· (C-)	11 154	2 21221

			i iouso	State of Manuar		t of Hoalth and		c Legible.	
			1 _ State	State of Marylar				2001.	07122
_			Registrar		Certificat	e of Death		No. 2 0 0 4	01106
	Physicia	an	Decedent's Name (First, Middle, Last	it)	Ma 1	20-11	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		SHEILA	MAG	CAMI	JOELL		0 2004	12:00 P.M
	Examin	er	4a. Facility Name (If not institution, give	1	4b. City,	Town, or Location of Deat		4c. County of Death	1 / -
			2103 PRESIBU			BALTIM	1 1000	^	1/4
1	Funeral			ex 7. Age (In yrs.	7 Months	1 Year If Under 24 Hrs Days Hours Min.	(Month, Dey, Yea	9. Birth	pplace (State or Foreign untry)
	Director	4	X11-08 0806	0	9 Yrs.		JUNE 12,1	740 MA	TRYLAND
	pur *		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	aho aho	č	114 011 416	11/2	0		1 -1		1 X Yes 2 □ No
	Sa-f	ecto	MARYLAND ^	1114	10f. Zig	TIMORE	0/1/	0.00	
	with t	ក្ត	10e. Street and Number	20.011	10r. 2lp	Code	109.1	Citizen of What Cou	unity?
	ours after death with the Maryland et', or Items 23a or 28a-f show Examiner must be molified at	Funeral Director	a 100 FRES	DURY STA	REE 1	0/0/	6	USA	)
	er de Item	une	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	If Yes, spec	dent of Hispanic Origin? (S offy Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Amer Black, White	
3	hours after turel', or Ite	by F	1 Never Married 2 Married 3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specity:	1011
5-0036	e E		15. Decedent's Ed		16a. Decedent's Usua	al Occupation	166	. Kind of Business/li	ATCK ndustry
ָה	filed within 72 Hygiene. other then "nai	Completed	(Specify only highest gra	de completed)	(Give kind of wo	rk done during most of wo se retired)	rking	Kind of Dusinessyll	ndustry
7	withi ene. then	щ	Elementary/Secondary (0-12)	College (1-4or 5+)	7.1	MAKER		7/111/ H	OME
2	e filed with at Hygiene other the	ပိ	17. Father's Name (First, Middle, Last)		110116		me (First, Middle, Maid		0/12
and	ed ital	Be	TOSCOU	H	trulou	ELIT	ABETIL	_	UENS
	→ 0 × .×	오	19a. Informant's Name/Relationship (	Tuno Print)	10h Mailion Address	(Street and Number or Ri	ural Pouto Number Cit		
Mary	C1 c2 m m		11.		190. Mailing Address	Some and Number of Al	VI An I		
	s 1 and f Health item 27 other to		VERMETER HENR  20a. Method of Disposition	1/ (5/5TER	Place of Disposition (Nar	THE BURY	Dete 20c.	Location - City or T	10-21216
5	Pages nent of the		Burial 2 Cremation 3		cemetery, crematory or c	ther place)	200.	Location - City of 1	Own, State
Baltimore,	E 0 3		* 4 □ Donation 5 □ Other (Specif	1) 1	T. ZIONG	EMERY 03-	12-04 /	4NSDOW	WE, MD.
<u></u>	mil par		21. Signature of Euneral Service Liper	1/1/1/10	22. Name an	Address of Pacility	BROWN JI	R. FUNE	RAL HOME
	89 1 8		Luguet	1. Willia	2140	DN. FULTS	ON AVE. &	BALTO, M	1021217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal one cause on each line.	th. Do not enter the mod	le of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
6.	Physician		Immediate Cause (Final disease or condition	Small (	colo Vien	Cance-			Onset and Death
н	/Medical		resulting in death)	Due to (or as a consec	quence of):	(074			
О	Examiner								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):				
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events						
Ć.	te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):				
9/	e be rsicia e bur	cal	(	d					
89	ificat g phy as th								
Box	nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of deliv	very
ŭ	atte f for	Cla	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c				Month	Day Year
o	the cy y the ichec	ys	9 ☐ Unknown	9□ Unknown					
<u> </u>	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions of		sulting in the underlying o	ause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
g	uires sigr d be	d b	Rheunstoil ar	・ナケック			Yes	2 □No 3 □ Pro	bably 4 Unknown
Records,	y req	ete					24a. Was an	24h Wasa aut	anny findings systable
ě	has has	mp					autopsy performed?	prior to co	opsy findings available ompletion of cause of
							1 ☐ Yes 2 🔀 1	No 1 ☐ Yes	2 No
Vital	ertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			ath (Check only one)		
	Physicien: The fav this certificate has al director, page 2	٩	1 Yes 2 No	1 Unpatient 2L	ER/Outpatient 3 □ DC		lome 5 desidence		ify)
_	ding P	OU	27. Menner of Death  1. ■ atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		8c. injury at Work?	28d. Describe how in	jury occurred	
Sio	death.	catl	2 Accident investigation 3 Suicide 6 Could not b		М	1 Yes 2 No			
Division of	irect irect	Certification	4 Homicide determined		nome, farm, street, factory fy)	/, office	28f. Location (Street City or Town, Sta	and Number or Rur ate)	al Route Number,
	rel D								
	Hosp 4 hou Fune ely fil	ca	(Check only 2 Medical Exag	ye cian: To the best of my knowner: On the basis of examina	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occi-	e, and due to the cause urred at the time, date a	(s) and manner as a	stated. to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	one)	and manner stated.					
	To viti	~	29b. Signature and title of certified	1	-	License number		Date signed (Month,	Dey, rear)
,			1///N			) DK 550	6) 03	108/0	7
	M		30. Name and address of person who	completed cause of death (Iter					
	Ü		Martin J.	Edolman	R.A. 22.	S. GREENE.	ST. BALT	O, MD	21201
x	Sta Registr		31. Date filed (Month, Day, Year)  MAR (1 9 2)	32. Registrar's Śigna	ature A		/		
		- 1 -	INSTANCE IN THE	11.164 1 6 TO ASS. 100 "	TO BE THE THE THE PARTY OF THE				

	2000 5000		State Registrar AMENID TTEM #10	State of Marylands  PER FH G829 3				Reg	ene 2001	31100
	Physicia	an	Decedent's Name (First, Middle, Last)  Judy	_	roner			2. Date of Death Month	Day Year	3. Time of Death  237 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	, reci er	4c. County of Deat	
<b>5</b>	Funeral		Mary Laud G		OSDI +a	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	NA 9. Birti	hplace (State or Foreign
	Director		031-10-2369	M 21XF 98	Yrs.	Months Days	Hours Min.	(Month, Day, Y 3-11-05		a.
	yland		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Be-1 s	ector	Md. NA		Balti	MOTE 10f. Zip Code		100	. Cilizen of Whal Co	Y☐Yes 2☐No
	h with t	al Dir	10e. Street and Number CHAUNCEY AVE. 826 Chauney Ave.			21217	7	109	USA	unity:
36	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show Alical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	l I	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.
21215-0086	72 hours natural' ical Ex	eted b	3 ¼ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates: ation completed)	16a. Deced	dent's Usual Occupa	luring most of workii	ng 16	b. Kind of Business/	
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired, nestic	)		ther Peop	le Homes
	Hyg Hyg int,	Be C	6th grade 17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland		ို	Samuel  19a. Informant's Name/Relationship (Type	Braxt		ng Address (Street a	Alice	I Route Number, O	Harvey City or Town, State, 2	(ip Code)
	nd 2 s ulth ar 27 is r trau		Mary Harris Johns				ey Ave., E			217
Jore,	e = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	b. Place of Dispo cemetery, cren t. Zion	natory or other place	<sub>в)</sub> 3–13-		c. Location - City or Charlotte	
Baltimore,	permit. Pag Department Important: any injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		22	. Name and Addres	s of Facility		more, Md.	21202
	202 2 3		23a. Part1. Enter the disease, or complic	ations that caused the	-	larch F.H. er the mode of dying			North Ave	Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Dara int	oru F	ailure				Interval Between Onset and Death
	/Medical Examiner		resulting in dealh)	Due to (or as a con	sequence of):	ovelemic	Shock) w	ith Acu	ete	
	be tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	CC (UZIX	1 0			
0,	ficate be executed physician and is the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):	mavescu	lar Coag	quatro.	71	
68760,	cate be physicia the bu	edical	d.							
.O. Box 6	ne death certi the attending hed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pre 1 Live birth 2 II 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
<b>Q</b>	w requires that it been signed by should be detac	by	Part II. Other significant conditions con	ributing to death bul nol	resulting in the u	nderlying cause give	en in Part I.		cco use contribute to	
I Records,	sicien: The law re certificate has bee rrector, page 2 sho	Completed						24a. Was an autopsy performe 1 ☐ Yes 2 ☐	prior to death?	topsy findings available completion of cause of 2 No
Vital	Physicien: this certificantal director.	o Be	25. Was case referred to medical examiner?	ospital:	2 ☐ ER/Outpatier	nt 3□ DOA Othe	26. Place of Death		ce 6 □Other (Spec	2.5.1
of	ding Phys	$ \mathbf{F} $	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea		f 28c. Injury Work		28d. Describe how		sny)
Division	or Atteno	Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp				28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
-	Hospitel 24 hours a Funerel etely filled	dical C		icien: To the best of my er: On the basis of exar and manner stated.						
159	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	Otto		29c. License	e number	290	I. Date signed (Monti	h, Day, Year)
	n,	1	Burnout	167		1894	184	ć	3/8/04	
	(6)		30. Name and address of person who co	1 1 1	0.0	Print)	d Gen	eral 1	tispite	1
4	St Regist	ate rar	31. Date filed ( <i>Month, Day, Year</i> ) MAR 0 9 2004	39. Registrar's S	signature	ME)				

DHMH 17 Rev 1/2001

ORIGINAL

RPD			1 - State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of He tificate of D	ealth and Death		Reg. No.	2004	07134
# #	Physicia /Medic		1. Decedent's Name (First, Middle, Las MAHIRI CARTER	SR.				2. Date of De Month March	2, 20		3. Time of Death
	Examin	er	4a. Fecility Name (If not institution, give Harbor Hospital  5. Social Security Number 6. S		ast hirthday)	4b. City, Town, or Baltimor				NA 9 Birtho	olace (State or Foreign
	Funeral Director			16 M 2□F 2A	Yrs.	Months Days		1in. (Month, De	1980	Cour	mo mo
e Maryłan	diffed at	ctor	MD 10b. County		TOWN OF LO						0d. Inside City Limits 1 <b>漢</b> Yes 2 □ No
ath with th	s 23a or 26 ust be no	Funeral Director	10e. Street and Number 2732 VIRGINIA			10f. Zip Code 2121	5			usA	
urs after de	"natural", or Items 23a or 28e-t show idical Examinat must be motified at	by Fune	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	l.	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 1 No	Specify:	(Specify Yes of No Jerto Rican, etc.)		Race - Americ Black, White, Decify: BU	
d C I C I J-0000 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-t shov any injury or other treumatic event, the Medical Examinat must be notified at 00cs.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of	working		of Business/Inc	dustry
å	and Mental Hygiene is marked other that surnatic event, the	Be	17. Father's Name (First, Middle, Last) NORVEL CARTER				18. Mother's	Name (First, Middle	, Maiden Su	NBER Imame)	
and 2 should	lealth and Mei m 27 is marki her treumatic	ပ	19a. Informant's Name/Relationship (I	Type, Print)	19b. Mailin	ng Address (Street a	nd Number or		er, City or T	own, State, Zip	Code)
S 1	nent of Hea nt: If item iry or other		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State		sition (Name of natory or other place	)	Date - 08 - 02	20c. Local	tion - City or To	own, State
Dall.	Department of Importent: If any injury or once.		21. Sign we of Fureign Service Lice	1	VA	Name and Address USHN C 51 BAUO: 1	s of Facility	E FUNER	AL SE	PRICE	9
1	nysician Medical xaminer		23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  Due to (or as a consequ	Va	er the mode of dying	such as care	o inel	rrest,		Approximate Interval Between Onset and Death
cate be executed	physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
The law requires that the death certifical		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
w requires that	an signed b	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did	1	contribute to the	ne cause of death?
The law re	S C1	Completed						24a. Was auto perfo Yes		prior to con	psy findings available mpletion of cause of
OI VICAL Physicien:	his certific I director,	To Be C	25. Was case referred to medical examiner? 1 ∑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien		r: 4 🗌 Nursin	Death (Check only only only only only only only only	dence 6		y)
Attending P	i ei	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e One Block of Injury. At he	28b. Time of	Work 1□Y	? 1	28d. Describe	ect	8ta-bhe	I Route Number,
DIV	within 24 hours after death.  To the Funerel Director: A completely filled in by the to		determined  29a. Certifier  1 Certifying Ph	building, etc. (Specify	STFE wledge, death	n occurred at the time	e, date and pi	City or To	cause(s) an	Maise	J CF
To the Hospitel or	within 24 h To the Fur completely	Medical	(Check only and the of confider	niner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my op	inion, death o	occurred at the time,	date and pla	ace, and due to	the cause(s)
	8			completed cause of death (Item	23a) (Type,	O.C.	М.Е.		Marc	h 2, 20	04
46	St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		1 Penn St	reet,	Baltimore	, Mar	yland 2	1201

State Registrar DHMH 17 Rev 1/2001

A. Facility Name (if not institution, give street and number)   44. Facility Name (if not institution, give street and number)   45. County of Death			. Decedent's Name (First, Middle, Last,	)				2. Date of Dea Month	th Day Yes	3. Time of Death
SECULIA DELIZABETA  S. Social Security Numbers  S. Social	/Medical			-444		4h Cihi Touro	or Location of Deat		4c County of D	
Social Sociality Number   Social	Examiner	1		street and number)						outi)
United Part   Control	Francis			x 7. Age	(In yrs. last birtho	(ay) If Under 1 Yea	r If Under 24 Hrs		N/A	Birthplace (State or Foreign
The state and Number   Specific   Specify	Funeral Director		212-32-9746	M 254 94	Yr	s. Months Day	s Hours Min.			
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FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   1   Unknown   2   Festal death   3   Ectopic pregnancy   1   Yes 2   No 9   Unknown   2   Festal death   3   Ectopic pregnancy   2   Month   Day   Year   4   Pregnant at time of death   5   Other (specify)	cian dical hiner	al Exam	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of)	):				5 ylar
1   Yes   2   No   3   Probably   4   Unknown		a 1			of orognapay					,
24a. Was an autopsy performed? 1   yes 2   No   25. Was case referred to medical examiner? 1   yes 2   No   26. Place of Death Check onlone  25. Was case referred to medical examiner? 1   yes 2   No   27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   yes 2   No    28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)		nysician/med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No	1 Live birth 4 Pregnant at	2 Fetal death					Day Tear
25. Was case referred to medical examiner?  1	Dhuniology Modio	2	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2  Fetal death time of death	5 ☐ Other (specify)	·		obacco use contribut	e to the cause of death?
25. Was case referred to medical examiner?  1	Dhwiologay/Modio	2	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2  Fetal death time of death	5 ☐ Other (specify)	·	1 🗆 \	obacco use contribut	e to the cause of death?    Probably 4
27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   27 Accident   5   Pending investigation   2   Accident   5   Suicide   6   Could not be determined   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)	Dhweleles Mode	2	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2  Fetal death time of death	5 ☐ Other (specify)	·	1 🗆 \\ 24a. Was autop	obacco use contribut res 2000 3 and 24b. Were sy prior deat	e to the cause of death?  ] Probably 4  Unknown  a autopsy findings available to completion of cause of 1?
Matural   5   Pending   (Month, Day Year)   Injury   Work?   1   Yes 2   No   1   Yes 2   No   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)   29a Certifier   W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	of Completed by Ohimicial Model	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes	1 ☐ Live birth 4 ☐ Pregnant at 1 9 ☐ Unknown  ontributing to death bu	2 🗍 Fetal death lime of death It not resulting in t	5 ☐ Other (specify) he underlying cause	given in Part I.  26. Place of De	24a. Was autop perfo	obacco use contribut (es 2) No 3   an 24b. Were prior  gen and 24b. The prior  gen and 24b. The prior  and	e to the cause of death?  Probably 4 Unknown  autopsy findings available to completion of cause of ??
29a Certifier & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	To Do Complete by Divinish and Tr	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  Part II. Other significant conditions co	1 ☐ Live birth 4 ☐ Pregnant at ' 9 ☐ Unknown  ontributing to death bu  Hospital: 1 ☐ Inpatie	2   Fetal death lime of death it not resulting in t	5 ☐ Other (specify) he underlying cause	given in Part I.  26. Place of De	24a. Was autop period 1 yes wath Check onl of Home 5 Resident	obacco use contribut  yes 2 No 3   an 24b. Were sy prior deat 2 No 1 No ne 6 Other (5	e to the cause of death?  Probably 4 Unknown  autopsy findings available to completion of cause of ??
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29b. Signature and the of certifier  29c. License number  29d. Date signed (Month, Day, Year)  MUTCL, Y, 2004	T- Do O Commission by Ohymer Manual	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 4 Pregnant at 1 9 Unknown ontributing to death bu  Hospital: 28a. Date of Injur (Month, Day)  28e. Place of Injur	2 Fetal death lime of death  It not resulting in t  It 2 ER/Outp  Y Year)  28b. Tir Inj	batient 3 DOA cause of Market	26. Place of De Other: Nursing	24a. Was autor period of the control	obacco use contribut  yes 2 No 3   an 24b. Were sy prior deat 2 No 1   dence 6 Other (S now injury occurred	e to the cause of death?    Probably 4  Unknown   autopsy findings available to completion of cause of 17 (es. 2) No
1/ ( MC) 252746 March, 9,2004	To Da Commission by Ohiminian	il Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions of examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death   1   Natural   5   Pending   1   Pending	Hospital: 1 Inpatier  28a. Date of Injur (Month, Day)  28e. Place of Injur building, etc.	2 Fetal death time of death at not resulting in t at 2 ER/Outp y Year) 28b. Tir Inji ary - At home, farm (Specify)	batient 3 DOA cause of the underlying cause of the underlying cause of the underlying cause of the underlying cause of the underlying cause of the underlying cause of the underlying death occurred at the underlying cause of the underlying cause o	26. Place of De Other: Nursing	24a. Was autop performent of the control of the con	an 24b. Were sy your of death of the control of the	e to the cause of death?    Probably 4
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 5, 2004 12:55 PM Paula Gerry Clarke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 916 Topmast Way Annapolis
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 XF 012-20-9251 89 Nov.30,1914 Lowell. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intem 27 le marked other then "naturel", or Itame 23e or 28e-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Completed by Funeral Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 916 Topmast Way 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Retired 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Stanislaw Gorski Marya Ciesla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Clarke Slaughter/Daughter 1002 Mount Airy Raod Davidsonville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nisky Hill Cemetery 3/9/2004 Bethlehem, PA Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician neta stat years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel dea 4 Pregnant at time of death 2 Fetel death 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) P.0. detached 9 Tunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2 10 No 3 Probably 4 □Unknown 1 Tyes page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 -NO 1 Yes 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ InpatienI 1 Yes 2 THO Other: Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 043236 Υ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2448 14011s Are Ste 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

**ORIGINAL** 

				State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Health and Maryland / Department of Death	•	_	07137
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	th Day Year	3. Time of Death
		/Medic		JOHN BERNARD CAIN III	MARCH	4 200 4 4c. County of Death	1232 AM
	4	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locetion of Death  4c. City, Town, or Locetion of Death  4c. City, Town, or Locetion of Death  4c. City, Town, or Locetion of Death		HARFO	1 1
				5 Social Security Number 6, Sex 7, Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	3/20/1948Birth	place (State or Foreign
		Funeral Director		220-50-3000 1 N 2 F 55 Yrs. Months Days Hours Min.	March 29	3/20/1948 Birth Col. 9,1948 Mar	y I and
		death with the Maryland ms 23a or 28a-f show frrust be notified at	lor	10a. State 10b. County 10c. City, Town or Location  Maryland Baltimore Baldwin			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		with the a or 28a be notifi	Funeral Director	Maryland Baltimore Baldwin  100. Street and Number 101. Zip Code 21013	1	IOg. Citizen of What Cou	intry?
		eath ns 23	erai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14. Was	ecify Yes or No-	14. Race - Amer	ican Indian,
	36	172 hours after death with the Maryla "naturel", or Items 23a or 28a-f shov olical Examiner must be notified at	by Fun	Armed Forces?  1 □ Never Married 2 X Married  1 □ Never Married 2 X Married  1 □ Never Married 2 X Married  1 □ Yes 2 X No Specify Cuban, Mexican, Puerto  1 □ Yes 2 X No Specify:  1 □ Yes 2 X No Specify:	Rican, etc.)	Black, White	
3	21215-0036	2 hou	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	16b. Kind of Business/I	ndustry
C032	215		ηpie	Elementary/Secondary (0-12)   College (1-40f 5+)	ang .	0 -++	
O		ed wii	S	2 Sales	- /5i 14i-d-f-	Construct	ion
	Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event, ILE M. ODGE.	To Be	John Bernard Cain Jr Winif	red Mar		
		nd 2 sho alth and ? 27 is me r treume		19a. Informant's Name/Relationship (Type, Print) Leslie J Cain  19b. Mailing Address (Street and Number or Rur 2700 Mercer Drive Balo	a/Route Number Iwin, Ma	r, City or Town, State, Z ryland 2101	ip Code) 3
120	Je,	of Hearlitem		M.W. in a Competion 2 Removal from State   cemetery, crematory or other place)		20c. Location - City or	
1	<u><u>Ĕ</u></u>	Page nent ent: If ury o		4 □ Donation 5 □ Other (Specify) ST JOHIT'S Cellie Let'y 13/6/C	_	Hydes, Mary	
3/	Baltimore,	permit. Pages Department of I Importent: If it any injury or or once.			Road Balt	timore, Maryla	
		Physician /Medical		23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Myocardal infarction  Due to (or as a consequence of):			Approximate Interval Between Onset and Death
13779	,09	be executed sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	e dese	case	
#	P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year
	ds, P	uires that signed b d be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to es 2∭No 3∏Pro	the cause of death?
	of Vital Records,	The law req ate has beer page 2 shou	Completed		24a. Was a autop perfor	med?   death?	opsy findings available ompletion of cause of
	ita	sian: artifica ctor,	Be C	25. Was case referred to medical axaminer?	th (Check only or	ne)	
7.7	<u>&gt;</u>	hysic his ce il dire	2	1 ⊈ Yes 2 No Hospital: 1 Inpatient 2 ⊈ ER/Outpatient 3 DOA Cutter: 4 Nursing Ho		ence 6 Other (Spec	ify)
00		Attending Physician: r death. ector: After this certifics by the funeral director,	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Accident Service (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No	28d. Describe h	ow injury occurred	
ain,	Division	Hospital or Attending Physician: The lav 14 hours after death. Funerel Director: After this certilicate has tely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Rreet and Number or Ru n, State)	ral Route Number,
Ü	X	아 그 수 한	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the orred at the time, or	cause(s) and manner as date and place, and due	stated. to the cause(s)
	1	To the I within 2 To the Complet	Me	29b. Signature and title of certifier  29c. License number		29d. Date signed (Month	¥ .
		0		Demand Juliana, MD, DME DOO 14206  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		March 4, 3	2004
	_	3		BERNARD YUKNA MD, DRE 7018 HOLABIRD AVE E	M OTLAS	1d 2122	۷
		St Regist	ate trar	31. Date filed (Month, Day, Year)  MAR 0 9 2004  33. Registrar's Signature			

DHMH 17 Rev 1/2001

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March

ORIGINAL

				For State	State o	f Marylan		artment of H	Health and I Death	Mental Hy	giene Reg. No.	2001	กรเรก
				Registrar  1. Decedent's Name (First, Middle, La	st)					2. Date of De	aath		3. Time of Death
		Physici		Faith Leigh	-	erby				March	7 Day	OO4	6:45 A M
		/Medic Examin		4a. Fecility Name (If not institution, give		nber)		4b. City, Town, o	or Location of Deatl			County of Death	911311
	1	Examin	e.	Oak Crest Care	Center			Parkvi	.11e		В	altimore	2
=		Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth av. Year)	9. Birthp	lace (State or Foreign
17		Director		010-20-9888	1□M 2□ F	80	Yrs.	Worth's Days	110013	OCT 3	1, 19	23 Mass	sáchusetts
4		pu ,		Usual Residence of Decedent  10a, State 10b, County		10c Ci	ty, Town or Lo	ncation				1	0d. Inside City Limits
Derby Fith	1	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show shit, the Medical Examinat must be notified at	7		•		rkville						1 ☐ Yes 2 🛣 No
Bu	,	r 28a-f sh	ecto		re ————	ra.	CKATITE	10f. Zip Code			10a Citi	zen of What Cour	ntn/2
1		vith ti	Ē	10e. Street and Number	1 #200	12		21234				Len or winat cour	itty i
0		a within 72 hours after death with jiene. r then "natural", or Items 23a or then "natural", or Items 23a or the Medical Examinal must be	Funeral Director	8820 Walther Bl		edent Ever in U	15 13			pecify Yes or N	USA	4. Race - Americ	en Indian,
1		lter d	'n	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Fo	rces?			Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, White,	etc.
	36	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	ates:		1 ☐ Yes 2 📉 No	Specify:			Specify:	White
6:45AM	21215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	pation	rkina	16b. Kir	nd of Business/In-	dustry
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0	bu	al Hy I oth	Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)	
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	Maryland	2 sho and is mu		19a, Informant's Name/Relationship					and Number or Ru				
20		es 1 and 2 should be filed within of Health and Mental Hygiene. I tiem 27 is marked other than ir other traumatic event, tha Me		Frank Derby/Hus	band	205	-	A CONTRACTOR OF STREET	Blvd. #3	Date Pa		11e, MD	21234
2/1/04	Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of		Chan	cemetery, cre etro C		Inc. 3-8	-04		timore,	
70	Balt	perrit. Par Departmen Important: any injury		21. Signature of Congral Service Lice LOWARD A. Signature	regorchi	.k	2	2 Name and Addre Cremation 299 Frede	ss of Facility I Society Erick Roa	of MD d Bal	Inc. timor	e, MD 2	21228
	<i>†</i>			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that of	aused the dea	th. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition		ASCI	10	endul	ine				Onset and Death
	7	/Medical		resulting in death)	a. Due to	(o as e consec	quence of):		-				
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	0.	the a	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐Unkn	nant at time of o	death 5	☐ Other (specify) _					
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	of	Phys this at dir	7	1 Yes 2 No	- 10	Inpatient 2	ER/Outpatie	ent 3 DOA	4 Nursing F	lome 5 ☐ Res 28d. Describe		Other (Specif	y)
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pt	Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	4 Homicide determine	build	ling, etc. (Spec	ify)			City or To	own, State	)	
		he Hosp n 24 hou he Fune pietely fil	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	miner: On the b	e best of my kn basis of examin iner stated.	owledge, dea ation and/or ii	nvestigation, in my	ime, date and place opinion, death occi	e, and due to the urred at the time	, date and	place, and due to	the cause(s)
		To t To t	Σ	29b. Signature and title of certifier	00	im			se number			e signed (Month,	
		χ.		M	16	ملك		D	13115		Mar	ch 7+h	2004
		10		30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type	, Print)					
	_	1		Jeffrey Landsman		8800 Wa		Blvd. I	Baltimore	, MD 2:	1234	refer the second	
			ate	31. Date filed (Month, Day, Year)		Regiatrar's Sign							
		Regist	rar	MAR 0 S	2004	MORINE	15	Spart i					
	Dł	HMH 17 Rev 1/2	2001		,			P					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 9:40 A Bertha W. Dunbar March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6157 Night Street Hill Columbia Howard If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2K□ F Yrs. Ohio 223 22 7679 May 2, 79 Director Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, to Medical Exampres must be confined at 28a-f ehow 1 Yes & No Director Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 6157 Night Street Hill 21045 Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ward Jeptha Weaver Sarah McLaughlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 730 Pleasant Hill Road Ellicott City, MD 21043 Theresa Wagenbrenner/Daughter Important: If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard. 3-8-2004 Marriottsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. permit. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINIM Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 5, 2004 n who completed cause of death (ttem 23a) Type, Print) ANNA POLIS RO 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2004 Registrar 9 MAR 0

Edith ENNIS

### **VOID**

# **CERTIFICATE** #

2004-7141

## SEE

**CERTIFICATE #** 

2004-01712

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			1 - For State Registrar Unpend Item#23a,		•					-	) N L	0711.
ı	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of Death
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P	Examir	ner	4e. Fecility Name (If not institution, give sti 3442 Carriage Hill					Location of Death		4c. County	altim	10ra
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last bii	rthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h		place (Stete or Foreign
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	/land		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	cation			<u> </u>	1	10d. Inside City Limits
	a-fsh	ctor	MD BALTI	MORE		RANI	ALLSTOWN					1 ☐ Yes 2 🙀 No
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	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral Director	3442 CARRIAGE HIL	L CIRCLE  2. Was Decedent Ev		13. V	/as Decedent of Hi	21133	ecify Yes or No-	14. Rad	e - Americ	U.S.A.
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2	should Ind Mening Ind Mening Ind Mening Indianatic	2	NEAL  19a. Informant's Name/Relationship (Type	- Print)		ELO\		MICHELI		Ch - T-		CABNET Code) 21133
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ē,	item 27		20a. Method of Disposition	-	20b. Place o	f Dispos	ition (Name of atory or other place		Date	20c. Location -		
Ē	Page ment cant: If ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	HEBRE		UNG MENS		2004	WOODL	.AWN,	MD
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5	tel or	Certification:	4 Homicide	building, etc.	(Ѕреспу)				City or Tow	n, State)		
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	IT: On the basis of e	xamination an	e, death nd/or inv	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the c	ause(s) and ma	nner as st	ated. the cause(s)
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nysician	n	Louise Ann Fr							4	1arch	4,	2004	Year	3. Time of Dea 8:30 P
Medical xaminer		4a. Facility Name (If not institution, give		ber)		4b. City,	Town, or	Location o				4c. County	y of Death	
		Joseph Richey Hosp	ice			Ba1	ltimo	ore			N	J/A		
neral		Social Security Number     6. S	ex 7 I□M 2K32kF	7. Age (In yrs	s. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of E (Month,	Birth Day, Yea	ar)	Cour	
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ם	-	10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	Od. Inside City Li
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of the state of th	lue	11. Marital Status	12. Was Deced	dent Ever in l	U.S. 13.	Was Deced	dent of Hi	spanic Orig	in? (Spe	cify Yes or !	No-		ce - Americ	
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LOUIS A. FRANKIN

			_	State of Marylan				•	•	
			1 - For State Registrar	Olaro ol many tan		rtificate of D		Reg.	2004	07144
I	Physicia		1. Decedent's Name (First, Middle, Las	0				2. Date of Death Month 4	DayYear	3. Time of Death
	/Medic		ANTHONY			TREEN	(0)		05 2004	11:12 B W
	Examin	er	4a. Facility Name (If not institution, give	street and number)	200	4b. City, Town, or L	ocation of Death	tu	4c. County of Death	1
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		210-02-4606	M 2□F 5.	5 Yrs.	Months Days	Hours Min.	(Month, Day, Yell MARCH 2)	1949 MA	place (State or Foreign intry) -RYLAND
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	ocation		/		10d. Inside City Limits
	with the Maryland e or 28e-f show the notified at	tor	MARUJANN N	IA		BAI	TIHOR	RE CI	TV	1ÆYes 2□No
	th the	Director	10e. Street and Number			10f. Zip Code			Citizen of What Cou	ntry?
	ath w	rai	2617 ROSE	WOOD AVENC	IE.		21216		45	A.
_	ter de	Funerai	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U. Armed Forces? 1   ↑ Yes 2   No	S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
003	hours after turel', or Ite	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No	Specify:		Specify: B	LACK
ر ک		Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of workin	g 16b	Kind of Business/Ir	dustry
N	within 72 ene. then *na'	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) ARPEN		15	EIF-EN	1PLOVED
ט פ	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)					(First, Middle, Maid		17 20 720
/lar		To B	GEORGE	GR	EEN		MINN	IE E	E. Cr	ASE
Mary	s 1 and 2 should I Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street an		-		
ტ ე	1 and Health em 27 ther t		20a. Method of Disposition	EN (JOKOT HER)	lace of Dispo	osition (Name of	Da	1) ALT	Location - City or To	0, 21218
aitimor	0 = 5		1  Burial 2  Cremation 3  □ '4  Donation 5  Other (Specify	Removal from State		matory or other place)			- 21	165 MD
= ====================================	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Licent	10/1	2	2. Name and Address	of Facility R	Pailed The	FILEDED	Al Home
ñ	Depa Impo any i	0 1	Withich	N. Willian	00	219871	FULTON	AVE , &	ALTO. M	AL HOME D. 21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	n. Do not en	ter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a WUTOHA	7 : -	87RCC	18081	2	l	lukuwn
	Examiner			Due to (or as a consequent	uence oi):					
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Ener Uncertying Cause (Disease or injury	Due to (or as a consequ	uence of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uance of):				-	
/6U	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cai E		d	201100 0171					
200	certificate nding phy. use as the			0.						
XOR	th cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of deliv	ery Day Year
o.	he dea the al	Physician/Med	1 Yes 2 No	4□Pregnant at time of de 9□ Unknown	eath 5[	Other (specify)			WOTER	Day Teal
٠ <u>.</u>	requires that the death een signed by the atter hould be detached for t	y Ph	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the u	nderlying cause given	in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	w requires that been signed to should be deta	ed b	bilated Car	ho my opat	my			1 ☐ Yes	2 No 3 Prol	pably 4 Unknown
Kecords		Completed by	Pulmonary	typerte	MS.	ion		24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
				01				performed 1 ☐ Yes 2 ☑		25 No
VItal	nysiclen: nis certifica director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ★ atient 2 □	ER/Outpatie	Other	26. Place of Death		6 ☐Other (Special	
0	a ⇒ E	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		at 2	8d. Describe how in		y)
310	endin sath. or: Aft	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		,,		as 2 □No			
DIVISION	of or Attendir after death. Director: At In by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
_	ne Hospitel or A n 24 hours after te Funerel Direc iletely filled in by		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno	wledge, deat	h occurred at the time	, date and place, a	nd due to the cause	(s) and manner as s	tated.
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medicel Exam	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my opi	nion, death occurre	d at the time, date a	and place, and due to	o the cause(s)
	To the within 2. To the complet	2	29b. Signature and title of certifier	Sico	nn	29c. License	number	29d. I	Date signed (Month,	Day, Year)
	IXI		30. Name and address of person who	completed cause of death (Item	23a) (Tyne	Print)	>- 00		in Manual	Jan 4
	K,		GMAZIELA	SZA150, MD	S	hari Ho	sprtal	of B-	thuof	6
	Sta		31. Date filed (Month, Day, Year)	\$2. Registrar's Signa	ture	Sil 1				
	Registr	वा		Service Services	Service Servic	WARRY .				

A. Kumhas GREEN

			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygie	_ / IIII la	07145
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medio		ARTHUR	GRAHAM		Month	Ol 2004	10:27 PM
Ì	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat		4c. County of Death	
			HARBOR HOSPITA		BALTIMORE		NA	
	Funeral		5. Social Security Number 6. Sex	M 2DF	oirthday) If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	(Month, Day, Y	ear) 9. Birthpli	ace (State or Foreign
	Director		Usual Residence of Decedent	60	ris.	09-05-10	143	<u>"8C</u>
	rland ow		10a. State 10b. County	10c. City, To	wn or Location		10	d. Inside City Limits
	Man F-f sh	to	MO NA	BALTI	MORE			1 K⊈Yes 2 □ No
	h the	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Count	ry?
	th wi	<u>a</u>	34 HILLVALE RO	AD	21229		USA	
	r des	Funeral	The state of the s	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
36	s afte	by F	1 Never Married 2 Narried 3 Widowed 4 Divorced	1 ☐ Yes 2 🐔 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	a	Specify: 121 n	0 L
Ş	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Medical Ever in er must be multiled at	edt	15. Decedent's Educ		a. Decedent's Usual Occupation	16	b. Kind of Business/Ind	CK
715	72 nic	Completed	(Specify only highest grade		(Give kind of work done during most of wo life. DO NOT use retired)	rking		,
212	e filed within at Hygiene. other then "	E	121H GRADE	N A	ROOFING		CONSTRUC	TION
g	be filed within 72 hours after death with the Marylan ital Hygiene. Id othar than "natural", or Items 23a or 28a-f show event, If a Madical Ever iner must be mutified at	Be (	17. Father's Name (First, Middle, Last) U	K ,		me (First, Middle, Mai		
yla	should be ind Mental s marked o umatic ev	၉	JOHN		THELMI			
Baltimore, Maryland 21215-0036	C 00 5		19a. Informant's Name/Relationship (Ty)	pe, Print)	b. Mailing Address (Street and Number or Ri		ity or Town, State, Zip	Code)
e,	es 1 and 2 of Health I Itam 27 I		DOROTHY GRAHAM  20a. Method of Disposition	20h Place	4 HILLVALE RD., BI of Disposition (Name of	Date 200	21229 c. Location - City or Tov	um Stata
סר	9 = 2		1 △Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemet	ery, crematory or other place)			vii, State
뜶	permit. Pa Departmer Important: any injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Fuperal Service Lice</li> </ul>				ALTO. MD	
Ba	permi Depa Impo any is		2)anol		22. Name and Address of Facility VAUGHN C. GREENE FI 5151 BALTO, NATU PIKE	WERAL SER	VICE	
			23a. Part1. Erker he disease, or compli	cations that caused the death. Do	o not enter the mode of dying, such as cardian			Approximate
	Priysician		shock, or heart failure. List only on Immediate Cause (Final	BRAIN STE	M STROKE			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence				3 days
	Examiner		Sequentially list conditions					
	p iii	Examiner	if any, leading to immediate	Due to (or as a consequence	e of):			
	and I-trans	хаш	Cause (Disease or injury that initiated events resulting in death) Last	.  Due to (or as a consequence	a of):			
8760,	icate be executed physician and s the burial-transit	al E		200 (0) (0) 23 2 0011304281101				
687	ficate physis the	edicat						
Box (	eath certific attending p I for use as	Ž.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deliver	v
	death certific se attending p ad for use as	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		Month E	Day Year
<u>Р</u> О	that the dened by the a	Physician/Me	9 🗆 Unknown	9L Unknown				
	ട് മ്	by F	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.		co use contribute to the	
ord	w requir been si should	ted				1 ☐ Yes	2 ☐NO 3 ☐ Proba	bly 4 □Unknown
ec	e law has b	Completed				24a. Was an autopsy	24b. Were autop	sy findings available pletion of cause of
E E	: The cate		9			performed	12 death? No 1 ☐ Yes 2	EJ-NO
<u> </u>	ician certifi rector	Be	25. Was case referred to medical examiner?	ospital:	Othor	ath (Check only one)		
oţ	Phys rthis raldi	To	1 Yes 2 No	Tumpatient 2 EP/C	dipatient 3 DOA 4 Nursing P	ome 5 Residence 28d. Describe how i	e 6 □Other (Specify)	
on	th. th. : Afte	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Time of Injury at Work?  M 1 Yes 2 No			
Division of Vital Records,	Attandi or death ector: A by the fi	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural	Route Number,
۵	tal or A	Certification;	4 Tromode	building, etc. (Specify)		City or Town, 3	(2(0)	
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier  (Check only 2 Medicel Exemin	icien: To the best of my knowledger: On the basis of examination a	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred	, and due to the caus	e(s) and manner as sta	ted.
	the hin 24	Medical	one)	and manner stated.				<u> </u>
<b>\</b>	To To	_	29b. Signature and title of certifier	./	29c. License number		Date signed (Month, D	ay, rear)
	0,		20 Name and address of	moleted cause of death (from 22)		5768 N	March, o	1,2004
	\		30. Name and address of person who co		SPITAL CTR, 3061	CHANA	ED CT R	ALTIMADS
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 .	2 HANDA	LK SI, U	THINORE
	Registr		MAR 0 9 2004	primary St. J.	graver			

		State of Maryland / Departmer Amend Item 26 perverb, G829, 03/09/04dhb Certification	nt of Health and M te of Death	dental Hy	giene	
		Decedent's Name (First, Middle, Last)	O Or Boatin	2. Date of Dea	ith Control	3. Time of Death 6
	sician	Norma Jane Grimm		Month		ear 004 215 am
	ledical aminer	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo			
Art Live	411111101	Mercy Medical Center	Baltimore		Baltimo	re City
Fune	eral	Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birti (Month, Day		Birthplace (State or Foreign Country)
Direc	tor	218-20-7257 /6 Yrs.		9/4/19		'irginia
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Manyl 1 sho	o.	Maryland Anne Arundel Gambrills				1 ☐ Yes 2 ื No
the 28a	Director		Code		10g. Citizen of Wha	at Country?
3a or		823 Annapolis Rd. 210	54		USA	
d 21215-0020 Illed within 72 hours after death with the Maryland Hygiene. Hydrer then "natural", or hems 23s or 28s-f show	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Dece	dent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race -	American Indian,
or its	E E	Armed Forces? If Yes, spe  1 ☐ Never Married 2 ☐ Married If Yes, Give 1 ☐ Yes	cify Cuban, Mexican, Puerto  2  No Specify:	Hican, etc.)		White, etc.
ours ours	dby	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	ZA NO Specify.		<i>Зреспу</i> :	White
72 h	r, me wedge	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usu (Give kind of we	al Occupation ork done during most of work (se retired)	ing	16b. Kind of Busin	ess/Industry
12 Mithigh	ם	Elementary/Secondary (0-12) College (1-4or 5+)	se retirea)		Hospit	o 1
The Had	L S	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle,		aı
ld be ld be ld be ked o	To Be	George Thomas Barnes	Bessie Ma	ae Powe	11	
arylan			s (Street and Number or Rura			ate, Zip Code)
end 2 salth a		Thomas T. Grimm, Sr. Husband 823 Annapo	olis Rd. Gambi	rills, N	D 21054	
S 1 e S 1 e		20a. Method of Disposition (Na.	me of	eb. 28	20c. Location - City	y or Town, State
imor Peges nent of 8 ant: If ite	<u> </u>	1XTBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mer	iT /	2004	Glen Bur	nie, MD
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 21 in marked other than "natural; or terms 23s or 28s-f show any Injury or which trainmain or one.	DICE.		nd Address of Facility	9.7		
0 885	8	May Handry HU373 Single	ton Funeral Ho nd Ave. S.W. (	ome, P.A	nie MD	21061
100		23a. Part1. Enter the disease, or complication. That caused the death. Do not enter the mos shock, or heart failure. List only one cause on each line.	le of dying, such as cardiac	or respiratory ar	est,	Approximate toterval Between
Physici						Onset and Death
/Medio	_	tmmediate Cause (Final disease or condition	cer			3 years
LAdiiii		resulting in death)  Due to (or as a consequence of):				
D +	Examiner	b				+
y xacui n end	xar	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying				
68760, cate be executed physician end the buriel-transit	al E	Cause (Disease or injury				+
687 ificate		resulting in death) Last  Due to (or as a consequence of):				
Box eath certi	2	d				
I Records, P.O. Box 6  The law requires that the death certific ate has been signed by the attending and 2 should he deteched for use as	. page z should be detected for use as the but	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23b. Did to	obacco use contri	bute to the cause of death?
D at the best best best best best best best bes	Phy			1 🗆 ٧	es 2 NO 3[	☐ Probably 4 ☐ Unknown
es th	b y				•	
Orc nequii	eted			24a. Was a perfor		4b. Were autopsy findings available prior to completion of cause
law i	nple				14	of death?
The	S S			13 Y	00 25 MG	1 ☐ Yes 2 ☐ No
Division of Vital Records, P.O. or Attanding Physician: The law requires that the diefer death.  The physician: The law requires that the diefer death.  The physician in continue the seen signed by the diefer-base in the diefer-base in the diefer-base in the physician diefer-base in the physician perfector names 2 should be diefer-base.	Be e	25. Was case referred to medical examiner?	26. Place of Death		X .	West -
Phys partition of	T. 1	1 Yes 2 A No 1 Dempatient 2 ER/Outpatient 3 Do	JA 4 Nursing Hor		ence 6 eurred	Specify) Nocities
On dling	to to	1 Naturat 5 Pending (Month, Day Year) Injury 2 Naccident investigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		1,545	
/iSi Attan	fica y	3 Suicide 6 Could not be	y, office			or Rural Route Number,
Displaying the property of the	Certification:	4 ☐ Homicide determined building, efc. (Specify)		City or Tow	n, State)	
Division of Vital Records, P.O. Box 63 To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours efter death. The Funeral Director: After this certificate has been signed by the attending prompletaly filled in by the funeral director, page 2 should be deteched for use as	Sai	29a. Certifier  (Check only  2   Medical Examiner: On the basis of examination and/or investigation	at the time, date and place, a	and due to the c	ause(s) and manne	er as stated.
he Ho in 24 he Fu	edicai	one) and manner stated.				
Tot vith	2	29b. Signatore and title of certifier	C. License number		9d. Date signed (N	
		Plomphillaro MI	V43734		2/26	12004
(5	5)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	A. A.	r 21	TIMA	/2004 LE MN 21202
	1	31. Date (filed (Month, Day, Year) 32. Registrate Signature	HUL PLAC	E DF	ILIMOK	E MI) 21202
Reg	State gistrar	31. Date filed (Month, Day, Year)  MAR 0 9 2004  32. Registrate Signature				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dav Year Physician Lee Greenwood march SOCH Jesse /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Baltimore Mercy-Stella Maris if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Months 1[XM 2□ F Director 02 15 53 MD 213-63-9870 with the Merylend 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryle Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at one. 1X Yes 2 □ No Director MD NA Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21215 U.S.A. 4900 Cordelia Funeral Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2√2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Black Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Foreman Bakery 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Melvin Greenwood Sadie Bowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4900 Cordelia Ave, Baltimore, Md Sadie Greenwood-Mother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Purial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/04 Baltimore Co. Md Woodlawn Cemetery 22. Name end Address of Facility 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Parti. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart taliure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Jivie dictal Immediate Cause (Final disease or condition resulting in death) tongre Cancer Examiner Due to (or as a consequence of): Examiner bunal-trensit Attending Physician: The law requiras that the daath certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of): nding physician and Division of Vital Records, P.O. Box 68760. Physician/Medical ate has been signed by tha attanding physi page 2 should be detached for use es the Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 □ Yes 2 ≥ No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by tha funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6. Hother (Specify) hospice 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No s aftar deeth. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) end manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 3/2004 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) PL PAUL isebeng 2. Registrar's Signature 31. Dete filed (Month, Day, Year) State MAR 0 9 2004 Registrar

		For State Registrar	State of Maryla	nd / Depa	artment of F	lealth and M	lental Hygi	_	4 0714
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last,  John H. Gleaso 4a. Facility Name (If not institution, give	n street and number)		4b. City, Town, o	r Location of Death	2. Date of Death Month March	Day Year 6, 2004 4c. County of Dea	3. Time of Death 7:45 a M
Funeral Director		6708 Carlinda Ave 5 Social Security Number 6 Security Number 579-10-2003 Usual Residence of Decedent		s. last birthday)  Yrs.	If Under 1 Year Months Days	umbia If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8/28/19		d thplace (State or Foreign bunity) hington, D.C
the Maryland r 28a-f show	Director	10a. State 10b. County  MD. Howard  10e. Street and Number	10c. C	Columb			10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√2 No
after death v	by Funeral Di	6708 Carlinda Av  11. Marital Status  1 Never Married Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:		210 Was Decedent of H If Yes, specify Cubs	)46 dispanic Origin? (Span, Mexican, Puerto Specify:	acify Yas or No- Rican, etc.)	USA  14. Race - Ame Black, Whit	
within ene. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ing 1	6b. Kind of Business  NSA /Gov	findustry
ould be fill Mental H arked ott atic even	To Be C	17. Father's Name (First, Middle, Last)  Joseph C. Glea  19a. Informant's Name/Relationship (Ty	son			18. Mother's Name	sie M. Po	aiden Sumame) offenberge City or Town, State, 1	
of Heals of Heals if item 2 or other		Mabel F. Gleaso  20a. Method of Disposition  1 GBurial 2 Cremation 3 GF	n/wife 20b.	6708 Place of Dispo cemetery, crei	Carlinda esition (Name of matory or other place	a Ave. Col	umbia,MD		
permit. Peg Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	Cı	22		ss of Facility Har	ry H.Wit	arriottsv zke's Fam cott City	ily F.H.Inc
Pri pe	cai Examiner	23a. Pan1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter or death, in a cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	er the mode of dyin	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death 2 Weeks
2 2 2	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregi 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
e law requires that the has been signed by ge 2 should be detac	Completed by Ph	Part II. Other significant conditions con Sicley Wash'c	ntributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.  Jour	1 ☐ Yes 24a. Was an	24b. Were au	the cause of death?  obably 4 Dunknown  topsy findings available completion of cause of
ysician: is certifice director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	28a. Date of Injury	☐ ER/Outpatier		4 🗆 Indishing Hor		ed? death? No 1 Yes  ce 6 Other (Special	2□ No
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th cumpletely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day Year)  28e. Place of Injury - At building, etc. (Spec	Injury home, farm, str	M 1 🗆	k? Yes 2 □ No		et and Number or Ru	ral Route Number,
he Hospital in 24 hours a he Funeral pletely filled	Medical (	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
within 10 th	Σ	29b. Signatur and title of certifier  30. Name and address of person who co	mpleted cause of death (Ite	am 23a) /Tunc		o 973		d. Date signed (Monti March 8	
Stat Registra		31. Data flied (Mopth, Gays Year)	32. Registrates Sign	X13637.1	AEDEAL	GROUP	Twokey	llnoth	e. Columb

		1	For State Registrar	State of	of Maryla		artment of rtificate of			lental Hyg	iene <sub>eg. No.</sub> 2	004	07	149
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	edica	al .		Beulah G			4b. City, Town,	or Location	of Dooth	March	7 20		8:10	P <sup>M</sup>
Exa	mine	er	4a. Facility Name (If not institution, g		imber)		Colum		or Death		4c. County of Death  Howard			
Fune	ral		Lorien Nursing H	Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birth			lace (State o	or Foreign
Direc			395 09 2941	1□M 2XF	94	Yrs.	Months Days	s Hours	Min.	Oct 20,	1909	Mich	igan	
pug *		-	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. fnside Ci	ity Limits
daryla f sho			MD Balti	moro.		Catonsv							1 🗆 Yes	2 🛛 No
the 1	TION I	rec	10e. Street and Number	INDIC		Cawiisv	10f. Zip Code			1	0g. Citizen o	of What Cour	itry?	
death with the Maryland ms 23a or 28a-f show	E KE	Funeral Director	15 Union Hall Co	ourt			21228	8			Unite	ed Sta	tes	
r deat		iner	11. Marital Status	12. Was Dec	edent Ever in orces?	U.S. 13.	Was Decedent of	Hispanic Or ban, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,		
s afte		by Fr	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes If Yes, G Year or f	2 🔀 No		1⊡Yes 2XXIN	o Specify	:		Spec	city: Tuth	ite	
d Z I Z I 3-0030 filed within 72 hours after Hygiene. sther then "natural", or Ite	2		15. Decedent's	1773	Jales.	16a. Dece	dent's Usual Occ	upation			16b. Kind of	Business/Inc		
7 or 2	Menalls	Completed	(Specify only highest s Elementary/Secondary (0-12)	grade completed	) (1-4or 5+)	(Give	kind of work don DO NOT use retir	e during mo red)	st of work	ing				
d will	9	E O	Zionionali, describali, (e 12)	4		Teac	her					ation		
Vid be file Mental Hy arked oth	V .	Be	17. Father's Name (First, Middle, La							e (First, Middle, I	Maiden Sum	ame)		
should be nd Mental	Datic	၉	Oscar Carl Peter	3.45		10h Mailie	a Address /Stra			Racine al Route Number	City of Tou	m State Zin	Codel	
Mar d 2 sho th and 7 is m	traun		19a. Informant's Name/Relationship Nancy Hoffman-Da							altimore			0006)	
ife, Maryiania Z 1 Z 13-0030  s 1 and 2 should be filed within 72 hours after death with the Marylan fileath and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show	other	-	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of matory or other p				-	n - City or To	wn, Stete	
Page:	70		1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		State M		ematory		3-8-2	2004	Catons	sville	, MD	
Baltimore, Ma permit. Pages 1 and 2 Department of Health a Important: If item 27 is	iy in		21. Signature of Funeral Service Lic	ensee	491044	22	2. Name and Add	ress of Facil	<sup>ity</sup> Harı	ry H. Wi	tzke's	s Fami	ly FH	Inc.
n ೩೭೯	s 8		Dan Colla	no -htt	te	4	112 Old	Colum	bia 1	<u>Pike Ell</u>	icott	City.	MD 21	1043
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that ily one cause on									Approximat Interval Bet Onset and I	ween
Physic	_		Immediate Cause (Finaf disease or condition resulting in death)	_ a	Cl.	dua.	nced	De	me	ulla				
/Medi Exami	_			Due to	o (or as a conse	equence of):	atten	Dich	ini	m.				
	2.74	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	equence of):	way	1	1	ntia n		-		
buted but	ransıt	Examin	Cause (Disease or injury that initiated events	c		fr	yrect	eis	Ler	7				
stobe executed by sician and	urial-t		resulting in death) Last	Due to	(or as a conse	equence of):	V -							
os/ou ificate be e g physician	d edi	dicai		d										
	Seas	Physician/Med	IF FEMALE:	23c. If yes, or	utcome of preg	nancy					23d. I	Date of defive	arv	
Geath cer	dfor	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	4□Preg	birth 2 □Fe Inant at time of		]Ectopic pregnan ] Other (specify)					Month		Year
by the C	tache	hys	9 Unknown	9□ Unk	nown									
w requires that the de	ep eq	by P	Part II. Other significant conditions			/	//	- A	4		3.7	ontribute to th		
ecord law requir as been si	pinor		u	MA	7 1	had	enge	un	<u> </u>	1 🗆 Ye			ably 4 □l	
e law	0 Z	Completed								24a. Was a autops perforr	n 24l sy med?	b. Were auto prior to cor death?	osy findings npletion of c	available ause of
VITAI MEC sician: The law certificate has t	r, pag		of Management and a madical						( )	1 ☐ Yes	2 X No	1 ☐ Yes	2[ <b>X</b> No	
OT VITAL Physician: T	al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospitaf:	Innatient 2	☐ ER/Outpatier	1 3 DOA	Thor.		h <i>(Check only on</i> me 5 ☐ Reside		ther (Specifi	v)	
	eralo	$\vdash \downarrow$	27. Manner of Death		of Injury onth, Day Year)	28b. Time o				28d. Describe ho			,	
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DIVIS To the Hospital or Att within 24 hours after d To the Funeral Direct	completely filled in by	Medical		ceminer: On the						red at the time, d				3)
To the Mithin To the	фшо	Me	29b. Signature and title of certifier					nse number	-0	2	9d. Date sig	ned (Month,	Day, Year)	
	N		150	A	-112	7	D	508	10		March	8, 20	)04	
	10		30. Name and address of person w	10 51	use of death (It	em 23a) (Type,	Print)	(n-	Cla	arlise	ulle	MI	) 011	029
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Re	gistr	ar	MAR 0 9 200	4	A Company	The same	-							

2004 07150 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4, 5.50 2004 MARY EVELYN BOLTON GEILFUSS March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Future Care Cherry Wood Reisterstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 🗓 F 88 213-60-6249 Yrs November 17, 1915 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 917 Elm Rd. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret KatherineMcDonnell Isaac Joseph Bolton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21212 510 Murdock Rd. Judith Dobson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Most Holy Redeemer Cem. Mar. 8, 2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21212 6500 York Rd. Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) I ULMONARY BSTRUCTIVE Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 munths?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DERTENSION 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe 1 Yes No No 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4☑Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funaral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)28595 alkan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7220 Park Heights Avenue, Baltimore, Maryland 21208 Tasneem Lakhani, M.D. 31. Date filed (Month Day Year) 32 Registrar's Signature State Registrar

			1 - For State RegistrarAMFND ITEM #	State of M	Marylar 29 3/09	nd / Depa 9/04 👀	artmen rtificat	it of H	ealth a	and M	ental Hy	/gien	20	04	07	151
	Physici /Medi		1. Decedent's Name (First, Middle, L SANUE	ast)	160	BERC	0				2. Date of De Month	eath Da H C	y 20	Year	3. Time	of Death
Page 1	Examir	er	4a. Facility Name (If not institution, g	ive street and numbe			4b. City,		Location o				. County		1	
			BRIGHTWOOD NURSIN  5. Social Security Number  6.		ne (In vrs	last birthday)	LUTH If Under		LLE If Under 2	24 Hrs	9 Date of Bi			IMORE		·
	Funeral Director		220-03-4848 Usual Residence of Decedent	10 M 2□F	9		Months		Hours	Min.	8. Date of Bi (Month, Di 02/14	7190	9	MARY	LAND	or Foreign
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	h with	al DI	1 HIGHSTEPPER	T APT.	604			208				U.S		Vhat Count	try?	
5-0036	filed within 72 hours after death with the Maryland Hyglene. that then "natural", or Iteme 23e or 28e-f ahow int, the Medical Examination at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Tes 2 If Yes, Give Year or Dates	t Ever in U ? (No			dent of Hi	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0.5	14 Race	e - America k, White, e WHI	an Indian, otc TE	
15-0	n 72 h	letec	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece	dent's Usua kind of wo	al Occupa rk done d	tion uring most	of workin	ıg	16b. K	ind of Bu	siness/Ind	ustry	
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ry B	hould d Men marka metic	ဍ	BERNARD G  19a. Informant's Name/Relationship	OLDBERG  (Type Bright)	<del>601</del>	-DMAN	- Add	(Cara sa s	RACHI			0.		ALPER		
Baltimore, Maryland 2121	es 1 and 2 should b of Health and Ment filem 27 ie markad r other treumetic e		ELSIE M. GOLDBER			•					Route Numb					NΩ
ore,	ges 1 a t of Hei If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			Place of Dispo	sition (Nan	ne of		Da	ate	20c. L	ocation - (	City or Tov	vn, State	.00
III	Pa Pa		*4 □ Donation 5 □ Other (Spec 21. Signatore of Funeral Service Lice	ify)	HAF	RSINA					/2004					).
Ba	permit. Departmine Importa any inju		21. Signature of Puneral Service Lice	ensee					s of Facility	201	LEVIN	NSON	BROS	S., I	NC.	
}	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	EUr	10NI	er the mod	e of dying	, such as c	WIN KL pardiac or	). PIKE respiratory a	ESVI irrest,	<del>- L E ,</del>		Approxima Interval Be Onset and	tween Death
	Examiner	9.		Due to (or a	EME	NTIA								1	DAY	5
8760,	ate be executed hysician and the burlat-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a		uence of):	7514	ON						14	'0N'	ins
P.O. Box 68	requires that the death certifica een signed by the attending pt hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pro						23d. Date Mon	of deliver	,	Year
ds, P	uires that signed to Id be det	É	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t			bute to the		
000	S S S	Completed									24a. Was		24b. W	ere autops	sy findings	available
E R	The ate has page	Som										osy rmed? 2,□No	de	rior to com eath? □ Yes 2	pletion of d !□ No	ause of
Vita	Physician: 1 this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				04-			(Check only o					
o	g Physer this	n 7	1 Yes 2 No	28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of		Bc. Injury Work	4644818		e 5 Resid					
sior	tending I leath. tor: After the funer	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	on		Injury	М	1 🗆 Y	es 2 No	0						
Division of Vital Records,	or At	Certifi	3 Suicide 6 Could not 4 Homicide determined	286. Place of In	njury - At ho tc. <i>(Specif</i> y	ome, farm, stre	et, factory,	, office		28	If. Location (S City or Tox	Street an vn, State	d Numbei )	r or Rural i	Route Nun	ber,
<i>(</i>	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical Certification;	29a. Certifier (Check only one)	hysician: To the best miner: On the basis and manner s	or examinal	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	, date and nion, death	place, an	d due to the	cause(s) date and	and man place, ar	ner as stat nd due to t	led. he cause(s	s)
	Vithii To the	ž	29b. Signature and title of certifier					License					-	(Month, Da	-	
	n		Spepte				I	000	531	50		NA	RCH	1 04	200	04
	2		30. Name and address of person who			23a) (Type, I	Print) 201-	-109	BA	cer	RIVE	n r	JECO	LRO	BA	122,
	Sta Registr	.6	31. Date filed (Month, Day, Year) MAR 0 9 7	32 Regist	rar's Signal		sell !		· · · · · · · · · · · · · · · · · · ·							

			For	State of Marylar		ent of Health and			07150
			1 - State Registrar	41	Certifica	ate of Death	2. Date of Death	3. No. 2004	0 / 152
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	LEONA	RD HE	EARN	Month	Day Year 3, 2004	9:30 PM
	Examin		4e. Fecility Name (If not institution, give	street and number)	11.	ty, Town, or Location of Deat		4c. County of Death	۸.
	Funeral		5. Social Security Number 6. S	x 7. Age (In yrs		Ba + Mo der 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthp	lece (State or Foreign
	Director		011-24-200	ZM 2□F 7	2 Yrs. Month	ns Days Hours Min.	AUG. 01	1931 M	RYLAND
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location		^	1	Od. Inside City Limits
	Ba-feh	ctor	MARYLAND N	IA		LTI MORE			1/∆Yes 2 No
	with the	Funeral Director	10e. Street and Number  4010 PENT	HURST AV	EALIE 101.	Zip Code $2121$	(5	g. Citizen of What Cour	ntry ?
	ems 2:	ınera	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	hours after death with the Maryland turel', or Items 23s or 28s-f ehow at Etaniner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1 🗆 Yes	2 2No Specify:		Specify: BL	1CK
21215-0036	72 hours 'naturel', dicel Exa	eted	15. Decedent's Ec (Specify only highest gra	ucation de completed)	16a. Decedent's U (Give kind of	work done during most of wo	rking	6b. Kind of Business/In	dustry
121	within ane. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DELL	VERY MAN		FLORISI	
	Hyg Hyg The	Be C	17. Father's Name (First, Middle, Last)	7	1 - 0 1	8. Mother's Na	me (First, Middle, M	100	- 1/ - 2
Maryland		ဥ	HLFRED  19a, Informant's Name/Relationship (	Type, Print)	19b. Mailing Addr	ess (Street and Number or R	ural Route Number,		CODE)
, Ma	s 1 and 2 should I Health and Mer Item 27 Is marke other traumatic		VIRGINIA HEAR	(WIFE)	42121	PENHURST.	AVE. BI	ALTIMORE,	40 21215
lore	00==		20a. Method of Disposition	Removal from State	Place of Disposition (cemetery, crematory)	Name of or other place)	Date / 2	Oc. Location - City of To	Philipper of the same
Baltimore	F 00 3		* 4 □ Donation 5 □ Other (Specifical Service Licental Se		ARKI SON 22. Name	and Address of Facility	20-046	TO FINES!	MULS, MO.
Ba	permit. Departi		MISLOU	MC	39	38 St. Faire	NAVE.	BALTO. MC	21217
			23a Part1. Enter the disease, or com shock or heart failure. List only Immediate Cause (Final	olications that caused the dea	ath. Do not enter the n	node of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Carair Due to (or as a conse	equence of):	ofave			72 hr
	Examiner	-	Sequentially list conditions,	b. Due to (br as a conse	rdial	Infave +	101		10 hr
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Mitral	Regui	rgifa Hun	, Ace	te	iour
,092	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a conse	equence of):		/		
68	÷ ÷	edical		d					
Вох	ath cert ttendin or use	lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 2 Fe	ital death 3 □Ectopi	c pregnancy		23d. Date of delive Month	ery Day Year
P.O. E	at the dea by the a tached fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5 Other	(specify)			
	es tha	by Physician/Med	Part II. Other significent conditions of	ontributing to death but not re	esulting in the underlying	ng cause given in Part I.	16	acco use contribute to the	
Records,	w requir been si should	Completed					1 X Ye		pably 4 Unknown
Rec	The law	ошр					autopsy perform 1 Yes 2	prior to co	mpletion of cause of
Vital		Be	25. Was case referred to medical examiner?	Harnitals 11			ath (Check only one		
of	Physic rrthis c sral dire	2	1 X Yes 2 No 27. Manner of Death	Hospital: 1 XInpatient 2( 28a. Date of Injury (Month, Day Year)		DOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Reside	nce 6 Other (Specification of the control of the co	y)
ion	Attending r death.	ation	1 Natural 5 Pending investigatio	n	Intury M	Work? 1 ☐ Yes 2 ☐ No			
Division	or Atterder de Directo	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fac cify)	ctory, office	28f. Location (Str City or Town	eet and Number or Rura State)	al Route Number,
6	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:		nysician: To the best of my kinner: On the basis of exami					
	To the H within 24 To the F complete	Medi	one) 29b. Signature applitte certifier	and manner stated.		29c. License number		d. Date signed (Month,	
	T X D		16/1/1	M.D	).	0 38570	1	Aurol 3, 2	.004
	241		- · · ·	completed cause of death (It	rem 23a) (Type, Print)	1111 1111111111111111111111111111111111	1 110 100	nuvoli3,2	diaso
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ORIGINAL

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			For State	State of Maryland		lealth and Mental H		
			Registrar		Certificate of		Reg. No. 200	4 0/153
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  JAMES	HILL		2. Date of E	erit .	3. Time of Death
7	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	r Location of Death	4c. County of Dea	ith
		Н	NORTHINEST	- HOSPIT	AL RAND	ALLSTOWN	DA	LTIMORE
	Funeral Director		5. Social Security Number 6. Sex 12 12-16-4950	M 2□ F	st birthday) If Under 1 Year Months Days	Hours Min. 8. Date of E. Month, J.	3irth 9. Bi Day, Year) 9/9 M	rthplace (State or Foreign ountry) ARVLAND
	p v		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Location			10d. Inside City Limits
	aho	5				211125		1⊠Yes 2 □ No
	28a-f	ect	10e. Street and Number	TIMORE	10f, Zip Code	SVILLE	10g. Citizen of What C	country?
	with with	급	7 SUABRA	NV Inaliz	101. ZIP 0000	21208	115	- A
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Decedent of H	dispanic Origin? (Specify Yes or I	No- 14. Race - Am	erican Indian,
<b>,</b>	r ker	F	1/3 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No			Black, Wh	ite, etc.
ဗ္ဗ	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:	Specify:	BLACK
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23s or 28s-f show yith the Medical Examinat must be incitified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual Occup	pation during most of working	16b. Kind of Business	s/Industry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire		,	/ ^
7	filed wit Hygien other th	S	8 THGRADE		NEVERW	ORKED  18. Mother's Name (First, Midd	N/	14
and	buld be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)	1	1/1=0		~	0.11011
Ž	should be nd Mental marked o	7	19a. Informant's Name/Relationship (Ty)	an Print)	19h Mailing Address (Street	DORIS and Number or Rural Route Num		2NISH
Ma	d 2 shouth and the and traum		Millian Boule	(SISTER)	CONTRACTOR OF CONTRACTOR	OKFORD CIRC		EVILLE MD 2128
	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Examinal results in chilified at		20a. Method of Disposition	20b. Pl	ace of Disposition (Name of	Date	20c. Location - City o	
Baltimore,	perint. Pages 1 a Department of Hea Important: If item any njury or othe once.		1. Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, crematory or other pla	1 5 6 1 6 4 1	BARRA	or want
₫	permit. Pa Deportmen Important: any njury once.		21. Signature of Funeral Service License	90	22. Name and Addre	ass of Facility 20	15 ALTIMO	Edo: Anno
B	permit. Decention Imports any nite		Vactuch 1	1. Willian	2925	HH, DROWN	BALTO. A	10017
K			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	. Do not enter the mode of dyin	ng, such as cardiac or respirator	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		SEPTIC ST	tock		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		70012		HOURS
П	Examiner		Conventially list conditions	INTOLA A	BOOMINAL	INFECTION		DAYS
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):	<del>-</del>		
	te be executed ystcian and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	»	6			
760,	e exe		resulting in death) Last	Due to (or as a consequ	ence of):			
876	cate t	dical		J				
x 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	3c. If yes, outcome of pregnar	nev		and Barrata	- Para-
Вох	atten for us	ian	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregnance	y	23d. Date of de Month	Day Year
P.O.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	Same (specify)			
	that ned b		Part II. Other significant conditions cor	stributing to death but not resu	ilting in the underlying cause gr	ven in Part I. 23e. Di	d tobacco use contribute	to the cause of death?
ds	quires n sigr	d b	CHRONIC RENAL	DISGASE, I	DIABETES ME	LCITUS: 10	□Yes 2/QNo 3□F	Probably 4 Unknown
Division of Vital Records,	w requir	Completed by	ELECTROIPE ABI	WIRMALITY.	HYPERTEN	C/620 24a. W	as an 24b. Were a	utopsy findings available
Re	The la	mo			/ / 0.2	pe	informed? death?	completion of cause of s
tal		a	25. Was case referred to medical			1 ☐ Yes 26. Place of Death (Check onl		3 2/3/10
<u>&gt;</u>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	lospital: Inpatient 2 E	ER/Outpatient 3 DOA Ct	ner: 4 Nursing Home 5 Re		ecify)
0	ig Ph ter th neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju		be how injury occurred	
ior	or Attending after death. Director: After in by the fune	Certification:	i Natural 5 Pending 2 Accident investigation			Yes 2 □ No		
ivis	r Atte	tiffic	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Location City or 1	n (Street and Number or F Town, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Cel		<u>l</u>				
	Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medical Exami	ner: On the basis of examinat	wledge, death occurred at the ti ion and/or investigation, in my	me, date and place, and due to the position, death occurred at the time	ne cause(s) and manner a le, date and place, and di	is stated. ie to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.	29c, Licen	se number	29d. Date signed (Mor	oth Day Year)
	T will		Day Sava	per MO		288	March 51	TI 2006
•	m		30 Name and address of person who co				0.001013	7
	• )			RCINGO CYCIV	NOUTIVET	1288 Hepital N	ledicel (a	The same of the sa
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	_ <u> </u>			
	Domint	ror	MAR (1.9.700)	4 France P	S Charles 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	07151
State of Maryland / Department of Health and Mental Hygiene	01127
Cortificate of Pooth	

	_	For State Registrar		Cer	tificate of L	Death		eg. No.		
Physicia	an	<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>Jon Harry Heiden</li> </ol>	)				2. Date of Dea Month March	Day	Year 2004	3. Time of Death
/Medic Examin		4a. Fecility Name (If not institution, give Union Memorial Ho	street and number)		**	Location of Death Baltimore	I HAT CA	4c. County		g jon
Funeral Director		5. Social Security Number 6. Security Number 12 12	x 7. Age (In yrs. last 6	t birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jun 21	Year) 1935	9. Birthpli Count I OWa	ace (State or Forei
		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Los	cation				10	d. Inside City Limi
fied at	tor	MD N/A		imore						1 SYes 2 □
sa or 28s Lbe noti	i Director	10e. Street and Number 4401 Roland Avenue	e		10f. Zip Code 21210			Og. Citizen of W		*
of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)		· Amenca c, White, e	etc.
natura Jisal E	eted	15. Decedent's Edu (Specify only highest grad	ication 1	16a. Deced	ent's Usual Occupa	ation furing most of workin	na	16b. Kind of Bu	siness/Ind	
than the	Completed	Elementary/Secondary (0-12)	College (1 tot 5 )			) hurch Mus		Religio	n	
and Mental Hygiene. is marked other than eumatic event, tre Me	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame	3)	
Menta arked atic ev	ToB	Vernon Clyde Heid	ien			Emma Mae	Brogde	n		
Health and tem 27 is my other treums		19a. Informant's Name/Relationship (Ty Mr. Donald Mooers				and Number or Rura venue, Ba				Code)
Department of Health Important: If item 27 any injury or other troons once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	etery, crem	sition (Name of natory or other plac ke Cremat	θ) M	lar 9	20c. Location - 0 Beltsvi		
Department o Important: If any injury or once.		21. Signature of Funeral Service Licens	L Mooget	22	Name and Address Cremation 8717 Gree	s of Facility and Fune in Pasture	ral Alt	ernativ Balti	es more,	MD
ysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final		^			r respiratory arr	est,		Approximate Interval Between Onset and Death
Medical and physicien and street transit	edicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent to or as a con	nce of):	reatic /	1435				
றன்		IF FEMALE:	d		SHAD.					
ed by the attending detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			Mon	of deliver th I	y Day Year
sign ed t		Part II. Other significant conditions co	ntributing to death but not resultin	ng in the ur	ndertying cause give	en in Part I.				e cause of death? ably 4 □Unkno
ate has been page 2 shouk	Completed						24a. Was a autops perform	med? de	/ere autoprior to comeath?	sy findings availand in the state of the sta
sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
this a	To To	1 ☐ Yes 2 MNo 27. Manner of Death	28a. Date of Injury 28	VOutpatien 3b. Time of	t 3□ DOA Sun 28c. Injun Work	4   Indising Hon		ence 6 ⊡Othe ow injury occurre		)
_ =	catior	1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be	(Month, Day Year)	Injury	M 1	Yes 2 □ No				
ieath. Ior: After the funer		4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		City or Tow	treet and Numbe n, State)	r or Hurai	Houte Number,
s after death. 31 Director: After 3d in by the funer	Certif			edne death	occurred at the tim	ie, date and place, a				
24 hours after death. e Funerel Director: After etely filled in by the funer	dical Certification:	29a. Certifier 1 Certifying Phy	rsician: To the best of my knowle iner: On the basis of examination and manner stated.			pinion, death occurre	od at the time, d	ate and place, a	114 440 10	the cause(s)
within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Certif	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	iner: On the basis of examination		restigation, in my op	number	2	9d. Date signed		
whin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certif	29a. Certifier (Check only one) 1 Certifying Phy	iner: On the basis of examination		restigation, in my op		2	9d. Date signed	(Month, D	Day, Year)
within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical Certif	29a. Certifier (Check only one) 1 Certifying Phy	iner: On the basis of examination and manner stated.	n and/or inv	29c. License	number	56	9d. Date signed	(Month, C	200H

State of Maryland / Department of Health and Mental Hygiene 200 i. 07155 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 March 8. 8:00 A. David Fredrick Helm, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1007 Mariner Road Joppa If Under 1 Year If Under 24 Hrs. Min. 8 Date of Birth (Month, Day, Year) Feb. 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Yrs 1953 Maryland 51 Director 215-60-1943 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Exertiner must be notified at 1 ☐ Yes 2 ☑ No Directo Harford Maryland Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 1007 Mariner Road United States or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 □ Yes 2 □XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Home Improvement 12 -0of Health and Mental Hygie Item 27 Is marked other permit. Pages 1 and 2 should be tite Department of Health and Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seibert He1m Doris David Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1007 Mariner Raod, Joppa, Maryland Mrs. Anita M. Helm (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar. Date 11, 20c. Location - City or Town, State 20a. Method of Disposition Method of Disposition

1 A Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdns ' 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility 21. Signature of Fune al Service Licensee T. Chisholm Funeral Services of Dulaney Valley, P.A.

200 E. Padonia Road, Timonium, MD 21093

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Internate Parkers Brian T. Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1/2 **Physician** MO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 26 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Natural 5 Pending investigation after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 101nas who completed cause of deal em 23a) (Type, Print) US/10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

			For						Mental Hyg		01 0	7150
_			1 - State Registra-AMEND ITEM #17	PER FH C	829 3/09	/04 <b>M</b> e	tificate of	Death		eg. No.	04 0	7156
	Physic	ian	Decedent's Name (First, Middle, Last		_ ~				2. Date of Dea Month	Day	Year	Time of Death
*	/Medi		CATHERINE L 4a. Fecility Name (If not institution, give			ARPER	4b City Town	or Location of De	March 4	4. 2004 4c. Count		6:45 P <sup>M</sup>
	Examir	ier	OAK CREST VILLAG				Parkvi		411		more Cou	ıntv
	Funeral	Г	Social Security Number     6. S	өх	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H				State or Foreign
	Director		212-09-2519 Usual Residence of Decedent	□M 21 1 F	98	3 Yrs.			Sept 4,		Maryla	-
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. In	side City Limits
	Ba-f sl	Director	Maryland Baltim	ore Cou	nty	Parkvi	lle				1	□Yes 2MNo
	with th	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Country?	
	be filed within 72 hours after death with the Maryland tal Hygiene. A contact than "natural", or Itams 23a or 28a-f show event, Itte Maulcal Examiner must be mailfied at	Funeral	8800 Walther Bo	ulevard				21234 Hispanic Origin?	(Specify Yes or No-		SA ce - American Inc	dian
9	or Itan	Fun	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv	rces?	1			(Specify Yes or No- erto Rican, etc.)		ck, White, etc.	1011,
003	hours after tural', or Ita	d by	3 ₩ Widowed 4 □ Divorced	Year or Da	ates:		☐ Yes 2 No	Specify:		Specif	White	e
15-	within 72 t ene. than *nati	Completed	15. Decedent's Ed (Specify only highest gra	lucation de <i>completed)</i>		16a. Deced	ent's Usual Occu kind of work done OO NOT use retire	pation during most of w ed)	rorking	16b. Kind of 8	usiness/Industry	
212	d with giene. ir thar	omo	Elementary/Secondary (0-12)	College (1	•		memaker	,,,		Own	Residenc	<b>.</b>
P	al Hygie d other	BeC	17. Father's Name (First, Middle, Last) CHARLES EDWARD M		±+7			18. Mother's N	ame (First, Middle, I			
ر ل ال yland 21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", "aurnatic event, Ita Maulcal Exa	7	Mr. Bruce C. Mor	ean (No	opom)				ine M. Hu			
Na Na	d 2 sh th and t7 is m traum		19a. Informant's Name/Relationship (1		1		_		Rural Route Number			en turn error
ē,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic stones.		Mr. Bruce C. Morg		20b. F	Place of Dispo	Uak Wn1 sition (Name of natory or other pla	te Road,			City or Town, S	
4/64 Baltimore	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from S	State				/8/2004	Raltim	re Mar	vland
4 Sait	permit. Departr Importa any inj		21. Signaturi Furera convice usan	A POOL	m	22	Name and Addre	ess of Facility	ld Europe	1 Home	Tma	, at the
al	00 F # 0		Martin D. Law 23a. Partl. Enter the disease, or compshock, or heart failure. List only	SON	wood the deet	b Do	6500 Yor	k Road,	Baltimore	. Mary	, inc. <del>land 212</del>	21.2 oximate
	Dhysisian		immediate Cause (Final	one cause on ea	ach line.	11 E	ar the mode of dyl	ng, such as cardi	ac or respiratory arre	<b>95</b> 1,	Inten Onse	val Between et and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a conseq	uence of);				-		
	Examiner		Sequentially list conditions.	b		CAD						
	led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to t	or as a conseq	uence of).						
- 15	te be executed ysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):						
25 1760	ite be iysicie ne bur	cal		d								
0 × 68	death certificate I attending physi I for use as the t	Physician/Medi	IF FEMALE:		17700							-
Bo	death c e attend ed for us	cian/	in the past 12 months?		come or pregna rth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnanc Other (specify)	у		23d. Da Mo	te of delivery nth Day	Year
70	- m - m	hysi	1 Yes 2 No 9 Unknown	9□ Unkno		J. J.	Guisi (speeny) _					
S,	es tha gned be de	by P	Part II. Other significant conditions co	~	ath but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did tob	acco use cont	ribute to the caus	se of death?
ecord	w requir been si should I		Duenn	mia	<i></i>				1 🗆 Ye	s 2 No	3 Probably	4. Unknown
Rec	aw as E	ompleted							24a. Was ar autops perform	/	Were autopsy fin prior to completic leath?	dings available in of cause of
∂ S Vital I	iician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical					00 Bloom of B	1 ☐ Yes 2	₽No 1	Yes 2 N	0
	Physician: this certificantal director,	To B	eyaminer?	Hospital: 1 🗆 Ir	patient 2	ER/Outpatient	3□ DOA Oth	-	eath (Check only one Home 5 - Reside		er (Specify)	
S.R. on of			27. Manner of Death 1⊌Natural 5 ☐ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury	28c. Injui Woo		28d. Describe ho			
visio	or Attending after death. Director: After in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be		of laiun. At he	ome form stre	M 1 [] et, factory, office	Yes 2□No	28f. Location (Str	and and Music		
A À	afor A after Direction by	Certification:	4 Homicide determined	buildin	g, etc. (Specify	y)	et, ractory, office		City or Town	State)	er or Hural Houle	₹ Number,
X	Hospitel 24 hours a Funerel I tely filled	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exem	sician: To the	best of my kno	wiedge, death	occurred at the tir	me, date and place	e, and due to the ca curred at the time, da	use(s) and ma	nner as stated.	(-)
A	the the the	Medi	29b. Signature and title of certifier	and mann	er stated.	A L	29c. Liceos					
	5		) distribution of terminal	KI	1		4	12424		315	(Month, Day, Y	7al)
	X		30. Name and address of person who d	ompleted cause	of death (Item			) - [ - [	1	unkli	Ile Ana	
			31 Date filed Menth Day Year)	-	gistrar's Signa		00 WJ	Thes!	2/19	F - CC V C	one wu	21234
	Sta Registr		31. Date filed Manth, Day, Year)	A	Garana Sagha	A sec						

Amend Item 8,9 per FH,G829,03/11/State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month Year **Physician** 22 PM Luther 2004 L. Hammell 04 MArch /Medical 4b. City, Jown, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F Yrs. 145-12-0744 Director 81 NovMay 2,1922 New Jersey Usuel Residence of Decedent the Marylend 10a. State New 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** Jersey Mercer Hamilton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 135 Saw Mill Road 08620 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 □ ¥es 2 □ No If Yes, Give Year or Dates:1942-46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Completed by Specify: White 3€ Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry se filed within 7 el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Engineer Electrical Manufacturer 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Haalth end Mentel (unk) Hammell Jennie (unk) Cottrell Fred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 1007 Amberly Ct., Bel Air. MD, 21014
Date 20c. Location - City or Town, State Important: If item 27 any injury or other tr Patricia Hockman, Danonter 20b. Place of Disposition (Name o cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Princeton Memorial Park 3/9/04 Washington TWP, NJ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
McComas Funeral Home 1317 Cokesbury Rd., Abingdon, Md 21009 oaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requiras that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) by Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2000 1 Yes 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 TYas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ToF Hospital: 1 ☐ Inpatient 1 Yes 2 No iours eftar death. Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier complataly (Check only one) ţ 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) line W Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artment of I	Health and M <i>Death</i>	fental Hyg	iene 20	104 0	7158
_	Physic /Med		1. Decedent's Name (First, Middle, La: Walter J. Idzik	st)				2. Date of Dea Month March		Yeer	ne of Death
	Exami		4a. Facility Name (If not institution, give Joseph Richey Hos			4b. City, Town, o	or Location of Death	TEST CIT	4c. County	of Death	
	Funeral Director		220 10 )2/2	7-W	yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Novembe:	r 16,19	9. Birthplece (St Country) 26 Mary	ate or Foreign Land
	Aaryland f ahow	o.	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	J	. City, Town or Lo					10d. Insid	de City Limits
	with the Manual of the Manual	Direct	10e. Street and Number 3624 Roberts Plac		Darcinol	10f. Zip Code 21224	<u></u>			What Country? States	Yes 2 □ No
	1215-0036 within 72 hours after death with the Maryland ene. here.	by Funera	11. Marital Status  1 X Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates: 194			dispanic Origin? (Spe an, Mexican, Puerto Specity:		14. Rac	e - American India ck, White, etc.	n, uite
	215-00 Ihin 72 hou B. "natura Medical E	pleted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation		ent's Usual Occup kind of work done OO NOT use retired	eation during most of working	ng	16b. Kind of B	wI usiness/Industry	шие
	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Inspectment of Health and Mental Hygiene. Impertant: If item 27 is marked other than "natural; or Items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examinational be notified at once.	To Be Completed by Funeral Director	8 17. Father's Name (First, Middle, Last) Louis Idzik		1	aborer	18. Mother's Name Tillie (	(First, Middle, N		anufactur <sup>78)</sup>	ing co
,	Mary and 2 sho salth and I n 27 is ma er traums		19a. Informant's Name/Relationship (7 Irene Brooks/sist		19b. Mailin 514	g Address (Street Windwood	and Number or Rura Rd. Bal	Route Number, Ltimore,	City or Town, MD 21	State, Zip Code)	
10-	Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or othe once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			ition (Name of atory or other places  Cemete				City or Town, State	
1:45	Balt permit. Departr Imports any inju		21. Signature of Funeral Service Licen				ell-Wieder York Kd.	eld Fune	eral Ho	me, Inc.	Lara
7	Physician /Medical Examiner		23a. Pari 1. Enter the disease, or compined, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	Tastati	r the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approxi Interval	mate Between nd Death
7/2/24		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons							
-1	2 % 2	cal	resulting in death) Last	Due to (or as a cons	equence of):						
3	Records, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	Year
	rds, P quires that on signed b	by	Part II. Other significant conditions co	ntributing to death but not r	esulting in the un	derlying cause give	n in Part I.		_	bute to the cause of	
121K		Completed						24a. Was an autopsy performe	ear a	fere autopsy findingior to completion of eath?  ☐ Yes 2 1 No	gs available if cause of
H.	r Vital ysiclan: Ti s certificate director, pa	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 DOA Othe	26. Place of Death			Bush	5.
存然	On O		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury Work	at 28 es 2 □ No	e 5 🗌 Residen 3d. Describe how			102
Walte	DIVISION all or Attending s atter death. al Director: Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree cify)	t, factory, office	28	Bf. Location (Stre City or Town,	et and Numbe State)	r or Rural Route N	umber,
3	DIVISION To the Hospital or Attention 24 hours after deatl To the Funeral Director: completely tilled in by the	edical (	(Check only one) 2 Medical Exami	sician. To the best of my kiner: On the basis of examinand manner stated.	nowledge, death i nation and/or inve	occurred at the time stigation, in my op	e, date and place, an inion, death occurred	id due to the cau I at the time, date	se(s) and man and place, ar	ner as stated. nd due to the cause	9(s)
•	. 7	Σ	29b. Signature and title of certifier  2	D		29c. License	1			(Month, Day, Year)	/
	10		30. Name and address of person who co	empleted cause of death (Ital		int) N Eut	4170 awst P	Saltino	re M	21201	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 9 2004	932. Registrar's Sign	nature	A					

DHMH 17 Rev 1/2001

			For State Registrer	tate of Maryla	nd / Depa		Health and M	Mental Hygid	•	4.07159
	Physici /Medio	cal	Necedent's Name (First, Middle, Last)     Wilma Lucille  4a. Fecility Name (If not institution, give street)	Jones		4b. City, Town,	or Location of Death	2. Date of Death Month March 3	Day Year 2004	4:00р м
	Examir Funeral	ier	Carroll Hospital (	7. Age (In yrs	s. last birthday)		inster If Under 24 Hrs.	8. Date of Birth	Carrol	1 Sirthplace (State or Foreign Country)
<b>.</b> ■	Director		219-64-1213		Yrs.			July 7 1	.951   M	d. 10d. Inside City Limits
30.NE	death with the Maryland ms 23a or 28e-f ehow f must be notified at	irector	Md Carroll  10e. Street and Number		ykesvil	10f. Zip Code		100	g. Citizen of What	1 ☐Yes 2 ☐ No
γ	after death wi	Funeral Director		Nas Decedent Ever in Armed Forces?    Yes 21 No		2178 Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	
Waryland 21215-0036	be filed within 72 hours after death with the Marylar lal Hygiene. Id other than "natural", or Itams 23a or 28e-1 show event, the Medical Examinar must be notified at	Completed by	15. Decedent's Education (Specify only highest grade co	Year or Dates:	16a. Deced (Give i	ent's Usual Occu kind of work done OO NOT use retire	pation during most of worked)	ting 16	Specify: W  Bb. Kind of Busines  London F	ss/Industry
2 (LC)		To Be Com	9 17. Father's Name (First, Middle, Last) Joseph Irving Brown		wareh	ouse wor	18. Mother's Nam	e (First, Middle, Ma rine Brow	tiden Sumame)	
Mr.A.	iit. Pages 1 and 2 should irrment of Health and Men irrant: If Itam 27 is marke injury or other traumatic.	F-	19a. Informant's Name/Relationship (Type, White Lee Jones Jr.	(spouse)	7422 5	Springfi	eld Ave A	pt 7, Syk		Md 21784
Baltimore, Mar	permit. Pages I Department of H Important: If its any njury or ot		20a. Method of Disposition  1		ke View	sition (Name of latory or other pla Memoria Name and Addre		04 S	ykesvill	e, Md
J 88	Deparent Dep		Parts. Enter the disease, or complication shock, or heart failure. List only one complications of the shock o	ons that caused the decause on each line.	ath. Do not ente	or the mode of dy	195 Sykes ing, such as cardiac	VIIIe, Md or respiratory arres	21784 t,	Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner  bhysician and bhysician and the prijal-transit the prijal-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conse	rquativa di).	can	nocarci	noma		1 month
P.O. Box 68	The law requires that the death certificate be to has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medi	in the past 12 months?	f yes, outcome of pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pregnanc Other (specify)	y		23d. Date of d Month	elivery Day Year
rds, P.	w requires that the sound by sound be detacted by the sound be detacted by the sound be detacted to the sound be detacted to the sound be detacted to the sound be detacted to the sound be detacted to the sound be detacted to the sound be detacted to the sound to th	ed by Ph	Parl II. Dther significant conditions contrib	uting to death but not re	_	derlying cause gr	ven in Part I.			to the cause of death?  Probably 4 THAKnown
l Reco		Completed by	deep vein -	thromb	20515			24a. Was an autopsy performe 1 ☐ Yes 2 ☑	d? prior to	autopsy findings available completion of cause of es 2 No
Division of Vital Records,	To the Hospitel or Attanding Physician: Th within 24 hours after death.  To the Funeral Director: Alter this certificate completely filled in by the funeral director, pag	Certification; To Be	2 Accident investigation	8a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju Wo M 1	her: 4 ☐ Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how	injury occurred	
Divis	pitel or Att		3 Suicide 4 Homicide  29a. Certifier  1 Contifying Physicia	8e. Place of Injury - At building, etc. (Spec	cify)		me date and place	City or Town, S	State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	(Check only one)  29b. Signature and title of the tip			estigation, in my o	opinion, death occur se number	red at the time, date		ue to the cause(s)
	6		A . A	eted cause of death (Ite		Print)	37728	/ ./	5-5-0	1401
	Sta Registr		Alfred Lee- 31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 1007 6 0		washin	gton H	eights	WESTMINSKEP

JONES

Luciue

CILMA

Division of Vital Records, P.O. Box 68760,

			•				Ensure Ai lealth and M	-	iene	
	_	Stete Registrar			Cer	tificate of	Death	2. Date of Deat	eg. No. 200	. 01100
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Harold J. Jone				4. O. T	d and a d Bank	Month March	3 200	415 M
Examine	er	4a. Facility Name (If not institution, give st Sinai Hospital o		ore		- A	Location of Death		4c. County of De	
Funeral Director		5. Social Security Number 6. Sext 218-07-2403		(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 25	Year) 9. B	irthplace (State or Foreign Country) aryland
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City, Tow Balti						10d. Inside City Limits 1    Yes 2   No
after death with the Marylan or Iteme 23s or 28s-f show offer Catal be notified at	al Director	10e. Street and Number 1203 West 40th Str	eet			10f. Zip Code	1211	1	0g. Citizen of What 0	Country?
	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1x Yes 2 N If Yes, Give Year or Dates:		1	Vas Decedent of H Yes, specify Cuba ☐ Yes ※XXNo	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh	
permit. Pages 1 and 2 should be filled within 72 hours Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "netural; any injury or other traumatic event, II a Medical Exa once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5-		. Deced (Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of worki f)	ing	16b. Kind of Busines Baltimor	· ·
iled wii lygien her th nt, ILe	S	17. Father's Name (First, Middle, Last)			Mer	chandisi	ng 18. Mother's Name		Gas and El	
ld be fi ental h ked ot ic ever	To Be	Robert A. Jones	<b>.</b>				_	Marie V		
2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (Typ	e, Print)	198	b. Mailin	g Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
1 and 2 Heelth a sm 27 is ther trau		Birdie L. Jones W	ife	20b. Place of	203 of Dispos	West 40t	h Street		ore, Maryl	
Pages nent of I int: if its ury or o		XX Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Balti	more	sition (Name of patory or other place Nationa	$\pm -03/08$			Maryland
permit. Departm Importe any inju		21. Signature of Funeral Service License	o Cha	Ce	meţe	Ry and Address	ss of Facility —Henss—Se	eitz Fune	eral Home,	Inc.
205 2		23a. Part1. Enter the disease, or complic	ations that caused	the death. Do	not ente	3631 F	alls Koad	, Baltin	nore. Mary	land 21211
Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	DS			<u> </u>			Approximate Interval Between Onset and Death 6 days  10 days  5 years
	e.	Sequentially list conditions, if any, leading to immediate cause Errier University	Pinel Due to (or as a	MON		٦				10 days
be sicie	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Ong Due to (or <sub>c</sub> a) a	CSTIV consequence	e of):	heart	failu	P		5 years
rtificati ng phy s as the		IF FEMALE:								
the death certificate / the ettending phys ched for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	20071270		23d. Date of do Month	elivery Day Year
wrequires that the des been signed by the e should be detached f	۾	Part II. Other significant conditions cont atmost fibrillation		-			1/1 1			to the cause of death?  Probably 4 □Unknown
The law requisete has been page 2 should	Completed	Hypertension.	Corona	nyart	ery	dista	se_	24a. Was ar autops perform 1 - Yes - 2	y prior to	
Phyeiclen: The rthis certificete h ral director, page	To Be	25. Was case referred to medical examiner?	espital:	nt 2□ER/O	utnatient	3□ DOA Oth	26. Place of Death		e) nce 6 □Other (Sp	ecify)
nding Phy th. :: After this e funeral c		27. Manner of Death  Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y 28b.	Time of Injury	28c. Injun Worl			w injury occurred	56197
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director;	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At home, fa . (Specify)	arm, stre	et, factory, office		28f. Location <i>(Sti</i> City or Town	reet and Number or F , State)	Rural Route Number,
ne Hospi n 24 hour ne Funer pletely fills	Medical	29a. Certifier (Check only one) Certifying Physical Certification Physical Certification Physic		examination ar						
To the comp	Ž	29b. Signature and title of certifier	10	111	`	29c. Licenso			od. Date signed (Mor	
10		30. Name and address of person who con	npleted cause of the	eath (Item 23a)	(Typa. F	RES	- 000	1	larch 3,	2007
		ROLF KREUTZ,	ND SINA	41 HOSF	TA		LTHORE.			
Stat Registra		31. Date files (Manth Day Year) 4	32. Registra	r's Signature	no di	1				

	•	For State Registrar	State of Marylar				ealth and Death		Re	g. No.	/		716
Physician /Medica Examine	al .	4a. Fecility Name (If not institution, give	Street and number)		_		Location of De	Neath	Date of Death Month	Day	Year Zoc ounty of De	4 27	230
Funeral Director		5. Social Security Number 240-30-3618		last birthday) Yrs.		1 Year Days	If Under 24 H Hours M	rs. 8.	Date of Birth (Month, Day, Oril 26	Year) 6,19	03 No1	A httplace (Sta Country) oth Ca	ate or Fore rolir
-f show	tor	10a. State 10b. County	timore 10c. Ci	ty, Town or Loc	cation	D	undalk						le City Lim Yes 2∑1
23e or 28	al Director	10e. Street and Number 1249 Willow	Road		10f. Zip	Code	21222		10		en of What C ted St	,	
- B	by runeral	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:	ĺ			ispanic Origin? n, Mexican, Pu Specify:	(Specify erto Rica	Yes or No- an, etc.)		I. Race - Am Black, Wh Specify: V		n,
than "nature than "nature the Medical E	Completed	15. Decedent's Ed (Specify only highest grad			ent's Usu kind of wo DO NOT u	se retired	ation during most of v	working			d of Busines		Corp
Mental Hyginarked other	lo Be Co	12 Years 17. Father's Name (First, Middle, Last) Jess Ollis			301 1	auy	18. Mother's N	1		faiden S			
27 is muser trauma		19a. Informant's Name/Relationship (T) Patty Leighton / C					and Number or Road I					Zip Code) 21222	
nt of rie		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	Place of Dispos cemetery, crem 1top Se	natory or c	ther plac		Date			son, I		
Department of Health a Important: If Item 27 is any Injury or other trappets.		4 Donation 5 Other (Specify, 21. Shouture of Funeral Service License)		22. D1	Name ar	nd Addres	ss of Facility Funeral Ave.	l Hor	me of I	Dund	alk. T	Inc. 21222	
sician ledical		23a Part1 Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line.  a. PNEUM  Due to (or as a consec	OPER				iac or re	spiratory arre	st,			imate Betweer and Deat
hysician and the burial-transit	CalEX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIVER Due to (or as a consected)  Due to (or as a consected)	uensa UI).	W. Y.	<b>T</b> 7	TS						
ed by the attending physician and detached for use as the burial-transit	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	ıl death 3 □	Ectopic p					23	d. Date of de Month	elivery Day	Year
5 8 3	ò	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying o	ause give	en in Part I.		23e. Did toba	acco use		o the cause robably 4	_
te has	Completed								24a. Was an autopsy perform 1 Yes 2	/	death?	utopsy findi completion s 2 No	
S Cer	o De	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Mainpatient 2 □	ER/Outpatient	3 D	Othe	26. Place of D		heck only one 5 🗌 Resider		□Other (Spe	ecify)	
arn. r: After this e funeral o		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		28c. Injury Work	at		Describe hov				
within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		et, factor	y, office		28f.	Location (Stre City or Town,		Number or F	lural Route I	Vumber,
Funer Funer stely fill	edical		sician: To the best of my kno iner: On the basis of examina and manner stated.										se(s)
To the	Σ	29b. Signature and title of certifier	100			c. License		,			signed (Mon		
2		30. Name and address of person who c	1.04 . 1		Print)		727			NAR		1 20	-20
State Registra		BRAD SADLO 31. Date filed (Month, Day, Year)	32. Registrar's Signal 2004			N A	VENU	ΛE	BALT	ZM	DRE V	MARYL	ANT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** MAIK 1:40 200 arch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COURT BURTONSVILL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 7 229.18-Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Mudical Exercitive roust be notified at 1 Yes 2 No BURTONSVILLE Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 USA 20866 or items 23a COURT Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel" or Hamany injury or other transmant. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No by Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EACHER EDUCATION 12 TH GRADE YRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SYLVIA PAYNE COLES OSBORNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ASTARTE KYLES CHASE KABBIT LAUREL . MO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 03-09-04 MO NATL LAUREL. MO \* 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MO 2 21. Signature of Funeral Service Lice See 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final disease or condition **Physician** CINOMOR 1001 M resulting in death) /Medical Due/to (or as a consequence of) Examiner ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit the attending physician and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day be detached for in the past 12 months2 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one, Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this in by the funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Matural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Char

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 9

B

MN

		Registrar  1. Decedent's Name (First, Middle, Last)			artment of Health rtificate of Deat	2. Date of D	eath	3. Time of Dea
ysici		Jean	Kinsey			Month March	05	Yeer 2004 8:33 A
Medic camin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location		4c. County	
· Carrini		St. Agnes Hospit	al		Baltimore			N/A
neral	1	5. Social Security Number 6. Se:	x 7. Age (In yrs.		If Under 1 Year If Und Months Days Hour	s Min. 8. Date of B	irth Day, Year)	Birthplace (State or For Country)
ctor		210-74-2092	<sup>3 M 2</sup> (XF) 44	Yrs.		MAY 1	9, 1959	Maryland
1000		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation			10d. Inside City Lis
3	5	Maryland N/A		ltimor				1 X Yes 2 □
틝	ect	10e. Street and Number			10f. Zip Code		10g. Citizen of	What Country?
3	ā	1203 Haverhill Ro	pad		21229		USA	,
1	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. 1	Was Decedent of Hispanic	Origin? (Specify Yes or N		ce - American Indian,
Her	필	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	i	If Yes, specify Cuban, Mexic			ck, White, etc.
3		3 ☐ Widowed 4 ☐ Živorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No Spec	rty:	Specil	% White
100	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deced	dent's Usual Occupation kind of work done during m DO NOT use retired)	nost of working	16b. Kind of B	Business/Industry
N.	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen			Own Ho	ime
4		8		Homen		other's Name (First, Middle		
8/8	Be	17. Father's Name (First, Middle, Last)	C.a.			_		ne)
natic	은	William E. Kinse	, ,	10h 14-10	ng Address (Street and Num	elen M. Smyt		Ctata Ta Cada)
any injury or other traumatic svent. The Madical Examinet must be notified at annote.		19a. Informant's Name/Relationship (T) Helen M. Kinsey/Me			Haverhill Ro		ore. MD	
thar		20a. Method of Disposition		-	and the second second second second second	Date		21229 - City or Town, State
0 0		1 ☐ Burial 2 X Cremation 3 ☐ F	temoval from State		osition (Name of matory or other place)	2 0 0/		
jury	Н	*4 □ Donation 5 □ Other (Specify)  21. Signature □ Funeral Service License			ematory Inc.			nore, MD
any i		21. Signature Sulvad A.	regall	(	Cremation Soc 299 Frederick	ciety of MD,	Inc. timore,	MD 21228
		23a. Part1. Enter the disease, or comp	egorchlk					Approximate
dical liner	ier		Due to (or as a conseq	dence on.				
e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last	Due to (or as a conseq  C.  Due to (or as a conseq					
etached for use as the burial-transit	cal	if any, leading to immediate cause. Enter Underlying Cause (pisease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \$\infty\$ \$2 \$\infty\$ No \$\infty\$ No \$\infty\$ Unknown	Due to (or as a conseq c.  Due to (or as a conseq d.  23c. If yes, outcome of pregna 1	uence of): ancy I death 3 [ eath 5 [	□Ectopic pregnancy □ Other (specify)	320 Dia	Me	ate of delivery onth Day Year
ould be detached for use as the burial-transit	by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yds 2 □ No	Due to (or as a conseq c.  Due to (or as a conseq d.  23c. If yes, outcome of pregna 1	uence of): ancy I death 3 [ eath 5 [	Other (specify)		Modern Mo	
r, page 2 should be delached for use as the burial-transit	Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (pisease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \$\sigma \text{s} 2 \$\sigma \text{No} \text{y}\$  Sunknown  Part II. Other significant conditions co	Due to (or as a conseq c.  Due to (or as a conseq d.  23c. If yes, outcome of pregna 1	uence of): ancy I death 3 [ eath 5 [	Other (specify)	24a. Wa aut	Modulate American Modulate Ame	onth Day Year
Cu S	Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (pisease of injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \$\infty\$ \$ 2 \$\infty\$ No \$\infty\$ Vinknown  Part II. Other significant conditions co	Due to (or as a conseq c.  Due to (or as a conseq d.  23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  ntributing to death but not res	uence of): ancy I death 3 Ceath 5 Culting in the u	Other (specify)  Inderlying cause given in Pa	24a. Wa aut pér 11 es ace of Death (Check only	Model I tobacco use con	tribute to the cause of death  3 Probably 4 Onkn  Were autopsy findings avail prior to completion of cause death  2 No
ral director, page 2	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (pisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a conseq c.  Due to (or as a conseq d.  23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  ntributing to death but not res	uence of): ancy I death 3 [ eath 5 [	Other (specify)  nderlying cause given in Pa  26. Ph  26. Ph  1 3 DOA	24a. Wa aution of the second o	Model I tobacco use con	tribute to the cause of death  3 Probably 4 Onkn  Were autopsy findings avail prior to completion of cause death  1 Pos 2 No
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			1 - For Stete Registrar	State of Marylan	d / Depa		lealth an	d Mental Hyg	_	
<b>k</b>	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     ROSA  4a. Fecility Name (If not institution, give st.)	reet and number)		KAHN 4b. City, Town, o	r Location of D	2. Date of Dea Month March	Day Ye	3. Time of Death par 12: 41 A M Deeth
*	Funeral Director		070 IL 0013	10ME 7. Age (In yrs. 93		BALTIM  If Under 1 Year  Months Days	If Under 24	Hrs. 8. Date of Birth Day APR. 10	, 1910	N/A Birthplace (State or Foreign Country) GERMANY
	e Maryland Be-f ehow	ector	Usual Residence of Decedent  10a. State 10b. County  MD N/A		y, Town or Lo	IMORE				10d. Inside City Limits 1    Yes 2   No
	be filed within 72 hours after death with the Maryland tal Hygiene.  ad Other than "natural", or itema 23e or 28e-f ehow dother than "natural", or itema 24e or 28e-f ehow event, the Madical Examiner mant be notified at	Funeral Director	Tr. Maria Otatas	2. Was Decedent Ever in U Armed Forces?	.S. 13.	10f. Zip Code  Was Decedent of H If Yes, specify Cub	21215 dispanic Origin an, Mexican, Pi		10g. Citizen of Wha	U.S.A.  American Indian, White, etc.
2-0020	within 72 hours after ene. than "natural", or Ite he Wedical Eximine	þ	1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced  15. Decedent's Educi (Specify only highest grade	1 Yes 2 No If Yes, Give Year or Dates: ation completed)	16a Dece	1 Yes 2 No	Specify: pation during most of	working	Specify:	WHITE
land 212	be filed within tal Hygiene. Id other than " event, the Ma	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	SEAM	ISTRESS		Name (First, Middle,	GARMENT  Maiden Surname)	GIDEON
e, maryia	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	To	ISAAC  19a. Informant's Name/Relationship (Type RAPHAEL KAHN / SOI	N	15 M	ng Address (Street	and Number o	r Rural Route Numbe	IMORE, MD	ite, Zip Code) 21208
Baltimore	permit. Pages 1 Department of H Importent: If ite eny injury or ott		20a. Method of Disposition  1	CHE	VRA AF	osition (Name of matory or other pla HAVAS CHE 2. Name and Addre	SED 3/	5/2004 SOL LEVIN	RANDALLS SON & BRO	TOWN, MD
	Physician		23a. Part LEnt the disease, or completed in the cause (Final disease or condition)	Yons that caused the deat a cause on each line.						Approximate Interval Between Onset and Death
	/Medical Examiner	ier	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
/en,	e be executed /sician and e burial-transit	cal Examiner	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
O. Box 68	ath certificat attending phy ior use as th	by Physician/Medi	IF FEMALE:	ic. If yes, outcome of pregnic.  1  Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month	f delivery Day Year
Records, P.	w requires that the de been signed by the a should be detached to	ted by Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	1	,	ite to the cause of death?
_		e Completed	Depression  Hypothwidism  25. Was case referred to medical	v			26 Place of	24a. Was autop perfor 1 Yes	rmed2 dea 22 No 1 □	re autopsy findings available r to completion of cause of th? Yes 2 \( \sum \) No
Division of VI	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	itlon; To Be	examiner?	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju- Wo	ner: Nursir	ng Home 5 🗆 Resid		(Specify)
DIVISI	ital or Attenurs after dearral Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	fy) 			City or Tou	vn, State)	or Rural Route Number,
	the Hosp thin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check only 2 Medical Examin one)  29b. Signature and title of certifier	er: On the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	ppinion, death o	occurred at the time,	cause(s) and mannedate and place, and 29d. Date signed (A	I due to the cause(s)
1	£ <u>₹</u> £ 8		30. Name and address of person who cor	moleted cause of death (like	n 23a) (Tuna	036:	508	SHAO	- 4	4 2004
	9	ate	30. Name and address of person who con Z434 W BeWedt 31. Date filed (Month, Day, Year)	a. a.	Bal	timore	, M		215	
	Regist		MAR 0 9 200	14 Acres	B 0	backer				

State of Maryland / Department of Health and Mental Hygiene 2004 07165 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1415 PM MARCH 06, 2004 LIPKA WALTER JOSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTII'IU No. In the Inder 1 Year If Under 24 Hrs. Solution 1 Year If Under 24 Hrs. (Month, Day, Year)

JUNE 27, 1926 PENNSYLVANIA HEALTHCARE SAINT AGNES 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral X**M 2□ F 165-20-9536 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, it a Marical Examinal mater by notified at 1 ☐ Yes 2X No HOWARD ELLICOTT CITY Direct 10g. Citizen of What Country? 10e. Street and Number U.S.A. 14. Race - American Indian, Black, White, etc. 8001 BRANCHWOOD COURT 21043 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1∑|Yes 2 □ No |If Yes, Give Year or Dates: 1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AIRCRAFT MECHANIC AIRLINES 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental JOSEPH LIPKA JOSEPHINE SHEMANSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 8001 BRANCHWOOD COURT, ELLICOTT CITY, MD. 21043 BARBARA LIPKA/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State permit. Page Department \* 4 □Donation 5 □ Other (Specify) BAYVIEW CREMATORY 3/11/04 BALTIMORE, MARYLAND LILLY & ZEILER INC. FUNERAL HOME 21. Signature of Funeral Service Licensee once. 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE CARDIOMYOPATHY 7 Months **Physician** /Medical Due to (or as a consequence of): month Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine RENAL FAILURE 2 months HRONIC physician and s the burial-trans Due to (or as a consequence of): 24 months TRIAL FIBRILLATION Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 59398 March 06, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 900 CATON AVENUE, BALTIMORE, MD 21229 RUSTOGI. MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar oaks

			For State Registrar	State of Ma	aryland / Dep		Health and N	lental Hy	•	
	Physici /Medio		Decedent's Name (First, Middle, La Rosemarie Lusco	ast)		orimoute or	Dealli	2. Date of De Month March	ath -	3. Time of Death
	Examir		4a. Facility Name (If not institution, gir Maria Health Care	Center		Baltimor			4c. County of Baltim	
	Funeral Director			Sex 7. Ag 1 ☐ M ※ F	e (In yrs. last birthda 84 yrs.	y) If Under 1 Year Months Days		8. Date of Birt (Month, Da Aug • 10	y, Year)	Birthplace (State or Foreign Country) MD
	Maryland 8-f show	ctor	10a. State 10b. County MD Baltimor	·e	10c. City, Town or Baltimor					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ath with the 23a or 28 unt be not	Funeral Director	10e. Street and Number 6401 N. Charles S	t.		10f. Zip Code 21212			10g. Citizen of Wha	tt Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If Item 27 is marked other than "neturel", or Items 23a or 28a-f show or other treumatic event, the Modical Examinat must be nuffled at	ρ	11. Marital Status  XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2☑ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, \ Specify:W	American Indian, White, etc. hite
21215-0036	within 72 ho ene. then "netur he Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5	(Giv		pation during most of work ad)	ing	16b. Kind of Busin	
and 21	12 should be filed within : n and Mental Hygiene. r is marked other than "r reumatic event, the Mod	To Be Co	17. Father's Name (First, Middle, Las Charles Thomas L		tea	cher	18. Mother's Name		Maiden Sumame)	l schools
, Maryland	and 2 shoul alth and Mark	-	19a. Informant's Name/Relationship Bernice Feilinger	(Type, Print)			es St. Ba	al Route Numbe	r, City or Town, Sta	te, Zip Code)
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 [  1 ☐ Donation 5 ☐ Other (Special Control of the Contr	(fy)		position (Name of ematory or other pla ria Cemet	100)	Date 04	20c. Location - City Glen Arm,	
Bal	permit. Pa Departmer Importent any injury		21. Signature of Funeral Service Lice  23a. Part 1. Enter the disease, or con-	show Ken	akes M		iedefeld I			d. 21212
1760,	be executed have been supported by the purial-transit been supported by the purious by the purial-transit been supported by the purious by the purious been supported by the purious by the purious by the purious been supported by the purious by the	Icai Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence of): a consequence of): a consequence of):					Interval Between Onset and Death
P.O. Box 68	ath certifica attending ph for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of Month	delivery Day Year
ords, P.	wrequires that the de been signed by the s should be detached	ted by Ph	Part II. Other of inificant conditions	contributing to death bu		underlying cause gr	ven in Part I.			te to the cause of death?  Probably 4 Unknown
Division of Vital Records,	: The law r cate has be page 2 sh		Break	age che	26 19	n 4,00		24a. Was a autop perfor 1 🗆 Yes	sy prior reed? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sum \text{No}\)
Vit.	Physiclen: r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ☐ ER/Outpatio	ont 3C DOA Ot	26. Place of Death		ne) ence 6 □Other (5	7
ion of	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day			ow injury occurred	Бреспу)		
Divis	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc				City or Tow	n, State)	r Rural Route Number,
	ne Hosp n 24 hou ne Fune pletely fi	Medicai	29a. Certifier 1. Certifying Pl (Check only one) 2 Medical Exa-	nysician: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at the ti nvestigation, in my o	me, date and place, a opinion, death occurr	and due to the c ed at the time, c	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifie	ed 1 n	20	29c. Lieen	95507		29d. Date signed (M	
			30. Name and address of person who EDDIE NAKHUO.				suly R	> 216	204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	10.0° 0			, , , , , , ,	

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2004 Walter Adam Lubinski 7, **Physician** 7:38 P M March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Rossville Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 11,1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1₩ M 2□ F Yrs. Maryland Director 218-10-3600 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State ed other than "natural", or itams 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ➡ No Dunda1k Maryland Baltimore Direc 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 8060 Kimberly Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc Pagas 1 and 2 should ba filed within 72 hours after nent of Health and Mantal Hygiene.
ant: If item 27 is marked other than "natural", or its ury or othar traumatic event, the Medical Examination. 1 X Yes 2 No WWII If Yes, Give WWII Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: Baltimore, Maryland 21215-0036 White δ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Contractor 8 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theresa A. Miedzinski Walter F. Lubinski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8060 Kimberly Road Dundalk, Maryland Walter J. Lubinski / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Stanislaus Cem. B/10/2004 Baltimore, Maryland Important: I any injury o once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. permit. Departr 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the attending physician and hed for use as tha burial-transit The law requiras that the death cartificate be axecuted that initiated events resulting in death) Last DK CHRONIC & ENAL FAILIFE Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) datached 9 Unknown s been signad by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe 1 Yes 2 No certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **1** No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To uneral dir this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Naple Registrar's Signature State MAR 0 9 2004 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 l. Linda F. Moxley For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 1140 a M Linda F. Moxley 3 March 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number)
504 Ramblewood Drive #307 4b. City. Town, or Location of Death **Examiner** Harford Abingdon Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F 54 Yrs. 212-60-1109 10, 1949 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show notified at 1 Tyes 2 No Harford Abingdon Director MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number is 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or other traumatic event. If a Medical Example at must be 1 21009 United States 504 Randallwood Drive, Apt. 307 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖼 No Specify: White 1 ☐ Yes 2 →No Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hospitality Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Strickland Dorothy Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Carol Moxley/Daughter 130 S. Stokes Street, Havre de Grace, MD 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 5 **= 8** Mar 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pagé Department of Important: If any injury or once. Beltsville, MD 2004 1 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moorble Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due (or a) consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissase or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam and Due to (or as a consequence of) physician austre the burial-1 Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 📶 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? 2 No 1 Yes 2 🗆 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Fother (Specify) at scene 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28c. Injury at (Month Day Year) L8b. Time on 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Month Day subject smothered After 1 Natural 5 Pending 03:57AM 1 ☐ Yes 2 🗷 No investigation death. 2 Accident after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Fewn, Status Lew 2003 R. ve 307 6 Could not be determined 3 ☐ Suicide filled in by 4 Homicide ō To the Hospital o within 24 hours aft To the Funeral Di nome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 4 2004 OCME of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 30. Name and address of person who completed ca DO 31. Date filed (Month, Day, Year)

State Registrar MAR 0 9 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #19a PER INF G829 3/16/04 efficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Patricia T Muller March 7, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 69 Yrs. 215-32-2814 Director Mar 9, 1934 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3017 Orlando Ave 21234 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 timore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced 'natural' White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer other .... rages 1 and 2 should be file
Department of Health and Mental Hyg
Importent: If item 27 is marked Antiquy or other \*\*\* 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Henry Thomas Edith Louise Byewater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALVIN George F. Muller/Husband 3017 Orlando Avenue, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar 9 \* 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huli Cremation and Funeral Alternatives 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician relle /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) the 1 ☐ Yes 2<del>2 N</del>o ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 2 10 page 2 should Completed 1 Tes 3 Probably 4 Unknown peen Malank 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 35 No Other: 4 Nursing Home 5 Residence Medical Certification: To 1 🗀 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Division 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39099 Museum M 8 30. Name and address of per n who completed cause of death (Item 23a) (Type, Print) MD WILLIAMS 6601 N. Charles St., Towson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Pagas. MAR 0 9 2004 Registrar

**ORIGINAL** 

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			1 - For State Registrar	otato or ma		rtificate of D			. No. 200	4 07171
			1. Decedent's Name (First, Middle,		-			2. Date of Death Month		3. Time of Death
	Physici /Medi			oover.	Sr.			63	Day Ye	120 AM
7	Examir		4a. Facility Name (Irnot institution, g		. 1	4b. City, Town, or Lo			4c. County of D	eath
		-	Joseph Ritchi			Baltim	ore			N/A
	Funeral Director		5. Social Security Number 6	. Sex 7:-Age 1 1 1	(In yrs. last birthday,	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y	ear) 9.1	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					01100	1 19	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. In Important: I fire m 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Marylaid Examinar is used be notified at once.	ctor	10a. State 10b. County	/A	Balt	imore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with th	Funeral Director	10e. Street and Number 1512 Shield	s Place		10f. Zip Code	1217	10g	. Citizen of What	Country? SA
	er deg	nue	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
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12	withii iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 54		anitorio			Carl	Dealer
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Man	d 2 sho th and 7 ie mu traumu		19a. Informant's Name/Relationship Hedy Moorey	(Type, Print)		ng Address (Street and			ity or Town, State	a, Zip Code)
<u>စ</u>	1 and Healt tem 2		20a. Method of Disposition	WITE		esition (Name of matory or other place)			c. Location - City	or Town. State
Ö	ages ent of nt: If i		1 🖾 Burial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		matory or other place) Baptist Chui	mb 3/13	- 1 - 1	Jannin	
<u> </u>	mit. Partm partm portar / inju		21. Signature of Funeral Service Lic				,			Funeral STVCS
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a _ Ca	consequence on:	er the mode of dying, s	such as cardiac o	r respiratory arrest,		Approximate In 11 Between Dean
120 Am	eath certificate be executed attending physician and for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):					
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$\frac{3}{4}/bq$	0 0	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
₫.	res that the signed by be detact	/ Ph	Part II. Other significant conditions	scrintributing to death but	not resulting in the u	nderlying cause given in	n Part I.	23e. Did tobac	co use contribute	to the cause of de ?
Records,	quires n sign	d by	ASPENGI/	33/5				1 ☐ Yes	2 No 3	Probably 4 Proknown
8 6	law requir as been si 2 should l	olete						24a. Was an	24b. Were	autopsy findings available
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ital	ysician: Th	Bec	25. Was case referred to medical examiner?			26	3. Place of Death	(Check only one)	110	3/
< \2	d S	၉	1 ☐ Yes 2 ☐ No		t 2 ER/Outpatien		4 ☐ Nursing Hon	ne 5 Residence	6 Other (Sp	pecity) History
0 6	ding Ph h. After th funeral	lon	27. Manufer of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?		8d. Describe how in	njury occurred	/
Division	ten Jeat tor: the	ertification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be Dian of Injur	y - At home, farm, str (Specify)		2 No	8f. Location (Street City or Town, St		Rural Route Number,
20	spital or Al ours after of teral Directified in by	0								
Ch		edical	29a. Certifier 1 ertifying F (Check only one) Medicel Ext	Physician: To the best of aminer: On the basis of a and manner state	examination and/or in	n occurred at the time, overstigation, in my opinion	date and place, a on, death occurre	nd due to the cause od at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	1	110	29c. License nu	ımber	29d.	Date signed (Mo	nth, Day, Year)
	/		MANUA/II	MIMIL IN		0 (30)	12	6	3/4/1	14
	5		30. Name and address of person who	o completed cause of dea	ath (Item 23a) (Type,	Print)	FAI D	37/6/	Who	21210
	Sta	te	31. Date filed (Month, Day Year)	34. Registrar	Signature	VVVII	W	0110,1	14	140
	Registr	_	MAR 0 9 20	G4 · •	(ma	1				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 MARCH **Physician** 3, MARY LOUISE MOON 7:00p ™ /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner COCKEYSVILLE BALTIMORE BROADMEAD 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** JULY 16, 1915 AMERICAN SAMOA 1 ☐ M 2√2 F 560-28-1185 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinant perceiting a 1 ☐ Yes 21 No BALTIMORE COCKEYSVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 YORK ROAD 21030 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Marned Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Suld be GEORGE S. HATHAWAY FRANCES L. WOODCOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau MARTHA PAVLICK daughter 2640 CARNEGIE RD. YORK, PA. 17402 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition GREEN MOUNT 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/04/2004 BALTIMORE, MD. \* 4 ☐Donation\_ 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 21111 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.Ó. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) page 2 certificate 1 Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 ☐ Yes 2 100 4 P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier death (Item 23a) (Type Print) 30. Name and address of person who completed cause of 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 **Physician** /Medica Examine **Funeral** AT Director prmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In contant: If item 27 is marked other than "naturel; or items 23e or 28e-f show any injury or other traumatic evant, the Medical Evantion transit be notified at the parts. MADISON, JOHN 3/6/04 To Be Completed by Funeral Baltimore, Maryland 21215-0020 Physician /Medical Examiner

		State of Ma	arylallu / I	Cen	tificate of I	Death	u Wentai F	Reg. No.	200	4 (	)7173
ı	1. Decedent's Name (First, Middle, Last						2. Dete of Month	Death Dey	Yea		Time of Death
ŀ	John L. Mad  4a Fecility Neme (If not institution, give	lison				h City Town	or Location of De	CH 10	County of De	14/2	3 = 20 Pm
ľ	Stella Maris Hosp		ercy Hos	spit:		Baltin			V/A	ain	
	5. Social Security Number 6. Se		e (In yrs. last bi	-	If Under 1 Year Months Days	if Under 24		Birth Day, Year)	9. E	Birthplace ( Country) Vew Y	(State or Foreign
₽	Usuel Residence of Decedent					J					
	10a. Stete 10b. County Puerto		10c. City, Tow		ation						nside City Limits  ☐ Yes 2 📉 No
L	Rico San Juar	1	San	Juan	101 7: 0 1			10.00	4 14/1-1		
	403 Calle Sol				10f. Zip Code 00901			USA	zen of What	Country?	
		12. Was Decedent E Armed Forces?		13. W	as Decedent of H	ispanic Origin' n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ar Black, W		dian,
	1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	₀ 1961- 1965	1	□Yes 2M∏No	Specify:			Specify:	W	hite
	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a	. Decede (Give k	ent's Usual Occupa ind of work done o O NOT use retired	ation during most of	working	16b. Ki	nd of Busines	ss/Industry	
	Elementary/Secondary (0-12)	College (1-4or 5	+) Te		<i>o not u</i> se <i>retired</i> tory Mana			Infor	mation	Tecl	hnology
	17. Father's Neme (First, Middle, Last)	<u>J                                </u>			Tory rain		Name (First, Mide			1 100	Iniorogy
	John L. Madison						erine Gav		00,		
	19a. Informant's Name/Relationship (T)	ype, Print)	196	. Mailing	Address (Street a				r Town, State	, Zip Code	a)
	Shannon E. Kane/S				Arrowhead				ills,		21054
	20a. Method of Disposition		20b. Place o	f Dispos	ition (Name of atory or other plac	e)	Date		cation - City		itate
	1 ☐ Burial 2 ☐\\(\frac{\nabla}{\text{remation}}\) remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State			natory In		3-8-04	Ва	ltimor	e. M	D
	21. Signature of Funeral Service Licen	69/1		22.	Name and Addres	s of Facility				,	~
	Edward A. Gre	obrchik	-	20	remation 99 Frede:	Societ Cick Ro	y or MD. Dad Bal	inc.	e, MD	2122	28
	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a		200	sest we					Inten	roximate val Between et and Death
		h								i	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as a	consequ	ence of):						
	Cause (Disease or injury that initiated events resulting in death) Lest	)	Due to (or as a	consequ	ence of):						
		d									
_	Part II. Other significent conditione con	ntributing to death bu	it not resulting in	n the unc	terlying cause give	an in Part I	23h D	id tohacco	use contribu	ite to the c	cause of death?
	Takin Salah sigim Contaction of	mileum g to deam ou	it not resulting in	TO GIV	John Million Grand Grand			☐ Yee 2		Probably	
-							24a. W	as an autop	sy 24b	available	ion of cause
							1.	_Yes 28	ON6	1 ☐ Yes	2□ No
	25. Was case referred to medical examiner?					26. Place of	Death (Check onl	v one)			
	1 Yes 2 No	fospital: 1 ☐ Inpatier		tpatient	3□ DOA Othe	4 LI Nursin	ng Home 5□ Re	esidence 6	Other (Sp	pecify) in	OSPICE
-	27. Menner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b.	Time of njury	28c. Injury Work M 1 □ `	at ≀? ∕es 2 □ No	28d. Describ	e how injury	y occurred		350
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, fa . (Specify)	ırm, stree	et, factory, office			(Street and Town, State)	d Number or (	Rural Rout	le Number,
	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examir	sician: To the best of ner: On the basis of and manner stel	exemination en	, death o	occurred at the time estigation, in my op	e, date end pl vinion, death o	ace, and due to the	ne cause(s) e, date and	end manner place, and d	as stated. ue to the c	ause(s)
	29b. Signature and title of certifier	mariner ster			29c. License	number		29d. Date	e signed (Mo	nth, Day, Y	Year)
	M NG	-			DHO	5854		-	3/8/2	004	
	30. Neme end address of person who co	mpleted cause of de	eeth (Item 23e)	(Type, P	rint) OL PI	Bel	Limore		21202	2	
	31. Dete filed (Month, Day, Year)	32. Registra	r's Signature	+	~ 6		1111010				

State

Registrar

MAR 0 9 2004

within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit To tha Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

				For State Registrar	State of	Marylar		artment o			d Menta			04	07174
		Physicia	an	1. Decedent's Name (First, Midd			-		-	_	Mon	of Death th	Day	Year	3. Time of Death
	p.c	/Medic	al	Thelma Mary  4a. Facility Name (If not institution		ber)		4b. City. Toy	wn, or l	ocation of D	Mo-	_	4c. County	of Death	10:431 **
		Examin	er	-	bouale	Hosp	ital	Ros	- 4	3101			Bol		970
	F	uneral		5. Social Security Number			last birthday)	If Under 1 Y Months D	/ear	If Under 24 Hours N		of Birth th, Day, Ye	ar)		place (State or Foreign
	D D	irector		210-24-7623 Usual Residence of Decedent	ILM ZEIF	72	Yrs.				Apr	. 9,	1931	Peni	nsylvania
	rland	Mo to		10a. State 10b. County	,	10c. Ci	ity, Town or L	ocalion							Od. Inside City Limits
	Мал	notified at	tor	Maryland Balti	more	Bal	timore								1 ☐ Yes 2 No
	th the	or 28	Olrec	10e. Street and Number		<u> </u>		10f. Zip Co				10g.	Citizen of W	hat Cou	ntry?
,	ath w	8 23e	rall	9200 Franklin S			10 10		237		1/C		JSA 14 Bass	Amori	can Indian,
6.	ter de	Items Iner Ta	Funeral Directo	11. Marital Status 1 Never Married 2 Mai	12. Was Deced Armed Ford ried 1 ☐ Yes 2	ces?	7.5.	Was Decedent If Yes, specify	Cuban	, Mexican, P	uerto Rican, e	tc.)		k, White,	
$\leq 3$	OSC Durs a	Exam	by	3 ☐ Widowed 4 ☐ Divorce	If Yas, Give			1 ☐ Yes 2🎇	No	Specify:			Specify	Ţ	Vhite_
2	.1.215-0036 within 72 hours after death with the Maryland	"natural", or	Completed		nt's Education est grade completed)		(Give	deni's Usual O	done du	iring most of	working	16b H.	. Kind of Bu	siness/In	dustry 1ntv
_	LZTZ be within	than	dmo	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT use r retary	retirea)				overn		
+-	N ====	and Mental Hygiene. Is marked other than aumatic event, the M	Be Co	17. Father's Name (First, Middle	Last)		1 500.	recary		18. Mother's	Name (First, I	Middle, Maid	den Sumam	B)	
_	aryland	wenta irked itic ev	To B	Joseph Micha	el Mumich					Eli	zabeth	Ber	tha (	aspe	er
$\leq$	2 sho	and Is me		19a. Informant's Name/Relation				ing Address (S							
	e, M	I Health and Menial Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical		Susan Affleck E	Bauer - Nie			the latest and the la			d, Jarı Date		Location -		vland 21084
٤		2 = 2		1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (-		late		osition (Name of matory or other		37	06/04			-	
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2	Balt.			1 Stepler C	e / Klerey			1317 Cd	okes	sburv 1					, P.A. and 21009
17	Vr sple	*		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the dea	th. Do not en						,	-	Approximate Interval Between
		ysician		Immediate Cause (Final disease or condition resulting in death)	a Sels	15									Onset and Death
		ledical aminer		resulting in death)	_	er as a conse									
		.a. 466.	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	or as a consec								-	
	cuted	hysician and the burial-transit	Examiner	that initiated events	1 . DM										
9	8 <b>/ 6 U,</b> sate be exe	cian a ourial-1	Ex	resulting in death) Last		or as a consec	•								•
į	cate t	as the L	dlcal		d. Fnao	cart	15								
Ì	BOX 6	attending pl for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc								23d. Date	of deliv	ery
V !	deatt	the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2 ⊡Feta antattime of a		□Ectopic pregr □ Other <i>(speci</i>					Mor	ith	Day Year
6	rat the de	> 5	Phy	9 ☐ Unknown  Part II. Other significant condit			culting in the	andorh ing sous		o in Blast I	230	Did tobac	PO USO CORTO	ibuta to t	he cause of death?
	dS,	s been signed b should be deta	d by	Decubitusula								1 Tes		3 🔲 Prol	
	K requ	peen	Completed by	Auseus, Dement								. Was an	24b. V	Vere auto	opsy findings available
1	Fe ia	# (A	отр	The east of the	100,111,117	I V J IN	, , ,	31 / ().		7 01-11		autopsy performed Yes 2.2	2 B	rior to co eath?	mpletion of cause of 2□ No
	lan:	certificate rector, pag	Be C	25. Was case referred to medic	al				-	26. Place of	Death (Check	- 0	NO T		2010
	)† <	this ce al direc	ToE	examiner? 1 Yes 2 No		·	ER/Outpatie		Other	4 🗀 Nursir	g Home 5				(y)
	Sing P	h. After 1 funera	lon	27. Manner of Death 1 ☑Nalural 5 ☐ Pend	ng 28a. Dáte o (Month	t Injury n, Day Year)	28b. Time of Injury	of 28c.	. Injury Work	al ? es 2∐No	28d. Des	scribe how in	njury occurr	∍d	
	DIVISION Of VITAL RECORDS, Lor Attending Physician: The law requires t	death.	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place			reet, factory, or						or or Run	al Route Number,
i		s after	Certi	4 Homicide	buildin	g, etc. (Speci	ity)				City	or Town, S	tate)		
	DIVISION OF VITAL RECORDS, P.O. BOX 68/60, Hospital or Attending Physician: The law requires that the death certificate be executed	unera		(Check only 2 Medica	ing Physician: To the I	sis of examin	owledge, dea ation and/or in	th occurred at to	the time	e, date and p	lace, and due	to the cause	e(s) and mai and place, a	nner as s	tated. o the cause(s)
	To the P	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certific	and mann					number			Date signed		
	Ţ	≥ ∺ 3		▶ Oalman	- Atala	ndon		0		0000	÷	31	3/0	4	******
		10		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type	. Print)					-10		
		ソ		Dr. Johnny Alexo	000 P 79 br	Fronk	sin s	quole	Dr	IVe B	altim	410	MD, 2	123	ン
		Sta	te	31. Date filed (Month, Day, Yea	2004 32/Re	gistrar's Sign	lature	- AF 6					-		

		State Registrar  1. Decedent's Name (First, Middle, Last		,, -	7-061	Helcale	OI Deal		2. Date of Dea	ath	2004	3. Time of Dea
Physic		ROBER		Н.		MIL	LER	N	Month Iarch	Day ()4	Year 2004	8:10 A
/Medi Examir		4a. Fecility Name (If not institution, give	street and number)			4b. City, To	own, or Location				County of Dea	
		4715 Milford Terr					ckville				Montgo	
Funeral Director		5. Social Security Number 6. Se 207-52-8973	x 7. Age 1 M 2 □ F	i (In yrs. Ias 46	t birthday) Yrs.	If Under 1 Months	Days Hour	ler 24 Hrs. s Min.	B. Date of Birth (Month, Day APR. 27,	, 195	9. Bir	thplece (State or For ountry) PA
pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City.	Town or Lo	cation						10d. Inside City Lin
Maryla	ţō	MD MONTG	OMERY	,		CKVILL	E					1 □ Yes 2 □
J within 72 hours alter death with the Maryland jiele. r than "naturel", or Itama 23a or 28a-f ehow the Medical Exama her must be notified at	by Funeral Director	10e. Street and Number			,,,,	10f. Zip C	ode			10g. Citi	zen of What Co	ountry?
a 23a	ral	4715 MILTFRED TER		:	10.11	<u> </u>		853	7. V N		U.S.	
atter dea or itama	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 X						ify Yes or No- ican, etc.)		Black, Whi	te, etc.
urel', o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 25	No Spec	ify: 			Specify:	WHITE
in 72 h "natu edica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		16a. Deced (Give i life, D	ent's Usual kind of work OO NOT use	Occupation done during m retired)	ost of working	7	16b. Kir	nd of Business	/Industry
77 75 1-	omo	Elementary/Secondary (0-12)	College (1-4or 5	5+ /	ATTORI		, , , , , , , , , , , , , , , , , , ,			U.S	. JUSTI	CE DEPT.
be file tal Hy d othe event.	Be	17. Father's Name (First, Middle, Last)							First, Middle,	Maiden		
s 1 and 2 should be filed with f Health and Mental Hygiene item 27 le marked other that other traumatic event, that	2	BERNARD  19a. Informant's Name/Relationship (7)	vpe. Print)		MILLI 19b. Mailin			LMA	Route Numbe	r. City o	SI r Town, State,	LVERBOOK Zio Code)
and 2 s ealth an m 27 le			FATHER								4 19027	
of Health of Health if item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀	Removal from State	cem	retery, crem	sition (Name natory or oth	er place)	Da			cation - City or	
Pag tment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify,		SHAL			. PARK		the state of the s		ADELPHI	
permit. Pages 1 Department of H Important: If ite any injury or ot 20028.		21. Signature of Fune al Service Licens	<del>00</del> ″		22.		Address of Fa		SOL LE	EVIN:	SON & B	ROS., INC LLE, MD 2
		23a. Part1. Enter the disease or comp shock, or heart tailure. List only of	ications that caused	the death.	Do not ente						LIKESAI	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Hypertens		eroscl	erotic	Cardiova	scular D	isease			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):							
Ot a	ē	Sequentially list conditions, it any, leading to immediate	b. — Dua to (or as :	i consaquer	rea of).				-			
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.									
te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):							
icate b physic s the b	dlca		d									
n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			F				2	3d. Date of de	livery
that the death certificate ed by the attending phys detached for use as the	by Physician/Medical	in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic preg Other (spec					Month	Day Year
that the ad by t detach	Phy	9 ☐ Unknown  Part II. Dther significant conditions co	ntributing to death bi	ut not resultin	ng in the un	iderlying cau	se given in Pa	rt I.	23e. Did to	bacco u	se contribute to	the cause of death
aw requires that s been signed b s should be deta	d by					, ,			1 🗆 Y	es 2[	□No 3□P	robably 4 Dunkno
aw rec is bee 2 shou	Completed								24a. Was a		24b. Were a	utopsy findings availa
The lav	Com								perfor	med?	death?	2 □ No
ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.1		Check only or			
두드	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day	nt 2 EF	Bb. Time of		Injury at Work?		e 5 🗌 Reside ld. Describe h			ofy) at scen
ttending F death. ctor: After / the funer	atlo	1 Natural 5 ☐ Pending investigation	(Month, Da)	/ rear/	Injury	М	1 Yes 2	□No				
or Atta	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home (Specify)	e, farm, stre	et, factory,	office	28	If. Location (S City or Town	treet and n, State)	d Number or R	ural Route Number,
To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowle	edge, death	occurred at	the time, date	and place, an	d due to the c	ause(s)	and manner as	s stated.
in 24 t in 24 t he Fu pletely	Medical	(Check only 2 Medical Exam	ner: On the basis of and manner sta	examination ted.	n and/or inv							
within 24 To the F complete	Σ	29b. Signature and title of certifier	m. D				License numbe				a signed (Mont	
(2)	0	30. Name and address of person who c		noth (lts = 0)	201/7		O.C.M.	Е.	M	Marcl	h 05, 2	004
(2)												

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 35 P M Myrtle Patman McKee Jarch 04 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Havre If Under 1 Year 1+12ens NUrsing tartord Home if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ XF Yrs 258-05-7447 86 Director Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked othar than "natural", or items 23a or 28a-f ahow traumstic evant, the Medical Examinar must be multired at 1 ☐ Yes 2 XNo Directo Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3604 Aldino Road 21028 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Nurse Oral Surgeon 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: if Itam 27 is marked ott Mamie (Unk) Bray William (nmn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3604 Aldino Rd., Churchville, Md. 21028 William R. McKee / Grand Nephew injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State permit. Page Department o Important: if any injury or once. \* 4 □Donation 5 □ Other (Specify) Woodlawn Memorial Park 3-8-04 Greenville, SC 21. Signature P.A. P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart aillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrusis **Physician** , idiopathic pulnonary 3 years /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Dementia 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 05 temporosi After this certificate 2∏·No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attanding Physician: the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funaral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 020840600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n M.O. 15 SouthParke Street # 400 therdeen mornous Prashant Shukla 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

nother, Myrtle

		For 1 _ State	State of Ma	aryland			Health and M	lental Hy	giene	2004	0717
- EE		Registrar  1. Decedent's Name (First, Middle, La	st)		Cei	tificate of	Death	2. Date of D	3	.004	3. Time of Death
Physicia		_	F.	M	cAlee:	^		Month March	Day	Year /.	4:32 p M
/Medic Examine		4a. Facility Name (If not institution, giv			CHICE		or Location of Death			Inty of Death	1 4:32 p
		Gilcrest Center				Towson	n		Ba	ltimor	e
Funeral		Social Security Number 6. S	Sex 7. Ag		ast birthday)	If Under 1 Year Months Days		8. Date of Bi (Month, D	irth		place (State or Foreign
Director		219-10-2/4/	10 M 20 F	_78	Yrs.				2, 192.		yland
land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
the Marylan 28a-f show	io	Maryland Baltimo	ro	Lan	.sdowne	2					1 ☐ Yes 2√☐ No
r 28a	lrec	10e. Street and Number		Luaii	SUOWII	10f. Zip Code			10g. Citizen	of What Cou	ntry?
leath with the Maryla ns 23s or 28s-1 shor must be routiled at	a D	2407 Saratoga Av	enue			21227			USA		
1215-0036 within 72 hours after death with the Maryland ene. Than "natural", or items 23s or 28s-f show the Medical Exacting must be redified.	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Vas Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or N	0- 14. [	Race - America	
036 ours after d	by Fu	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 📆f			☐ Yes 2√x No		1110411, 010.7			hite
21215-0036 ad within 72 hours all gione. et than "natural; or the Medical Everal		3 Widowed 4 Divorced	Year or Dates:		16a David	lant's Havel Ossur					
21215-0 1 within 72 ho liene. r than "natu	lete	15. Decedent's E (Specify only highest gra	ade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work. id)	ing	160. Kind o	f Business/In	dustry
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be filed tal Hygin of other event.	BeC	17. Father's Name (First, Middle, Last	)				18. Mother's Name	e (First, Middle			<i>5</i> <b>C</b> 01C
ylan, ould be Mental arked o	ToE	Harry	F	ulkos	ki		Mamie		Sc	chmidt	
Maryland 12 should be file in and Mental Hy 7 is marked oth	1	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street	and Number or Rura	al Route Numb	oer, City or To	wn, State, Zip	Code)
2 2 3 4 7		George W. McAleer	Jr., (So:	n)	2406 5	aratoga	Avenue, L	ansdow	ne, MD	21227	
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ce	metery, cren	natory or other pla	C0)				
		* 4 □ Donation 5 □ Other (Special		Lou	_		ery 3/9/0				Maryland
Baltimo Baltimo permit. Page Department of Important: If Important: If any injury or a		21. Signature of Funeral Service Lice	1860				ens Ave.,				
		23a. Part Foter the disease, or com	plications that caused	the death.						7 2122	Approximate
A A T		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.		1					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as	) me	/ WV	u aus	easl-	CIL	$\nu$		1 year
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The state of the s	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequ	ence of):	I					o gara
xecuted and and II-transit	Examiner	that inflated events	c	m	nu	ensi	m				10 year
Box 68760, auth certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as	a consequ	e(te of)	Moto				_	A 1.444
68760, ficate be expression is the burian	edicai		d		W.	aperes	<u> </u>				n year
X 6 Sertifi	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icv				204	Date of deliver	
Box 6  Box 6  eath certif	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	у			Date of delive Month	Day Year
tribe diached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			,, ,					
Cords, P.O. vequires that the debean signed by the should be detached	by PI	Part II. Other significant conditions	contributing to death b	ut not resul	lting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use c	entribute to th	he cause of death?
>rds								1 🗆	Yes 2	3 ☐ Prob	ably 4 ⊟Unknown
BOTIS MILL BOX ( The law requires that the death certif the has been signed by the attending te has been signed by the attending bage 2 should be detached for use a	Completed							24a. Was		b. Were auto	psy findings available
	E O								ormed ala No	death?	mpletion of cause of 2 No
	Be (	25. Was case referred to medical examiner?			<u> </u>		26. Place of Death	h (Check only	one)	/	Harace
hys hys	၉	1 ☐ Yes a No	Hospital:		R/Outpatien		4   Nursing Ho			ther (Specif	HOSPICE
Sion of tending Ph leath.	lon	27. Manuer of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Injui Wor M 1		28d. Describe	how injury occ	curred	
ivision rattending for death.	icat	2 Accident investigatio 3 Suicide 6 Could not b	e Jac Disea of Init	urv - At hon	ne farm str	eet, factory, office	Yes 2 □ No	28f Location /	Street and Nu	mher or Rum	I Route Number,
Division of Attendant directors	Certification:	4 Homicide determined	building, et	c. (Specify)	1	set, lactory, office			wn, State)	mber of fibra	THOUSE NAMED ,
		29a. Certifier Certifying Pt	nysician: To the best	of my know	rledge, death	occurred at the til	me, date and place,	and due to the	cause(s) and	manner as st	lated.
the Ho the Fu the Fu mpletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	f examination	on and/or inv	estigation, in my o	opinion, death occurr	ed at the time,	date and place	e, and due to	the cause(s)
To the P within 2. To the I complet	Σ	29b. Signature and title of certifier	NIL	- 44		29c. Licens	e number	0	29d. Date sig	ned (Month,	Day, Year)
		Mularill	theun	rm,	2		13707	9	3-6	04	
0)		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)					
		31 Date filed (Month, Cay York)	WICC/16	ar's Sinna	149						
Stat Registra		31. Date filed (Month, Day, Year)	104 A Sun	es S	ire A	الماما					

			1 State Registrar	State of Maryl		artment of H rtificate of I		Re	g. No. 200!	07178
	Physici /Medio	al	Decedent's Name (First, Middle, Last)     GLADYS REBECCA      As Fecility Name (If not institution, give si		NEST	4b. City. Town, or	Location of Death	2. Date of Deat Month MARCH	3 , 2004 4c. County of Dea	3. Time of Death 7:30p M
	Examir Funeral	er	2029 STRINGTOWN  5. Social Security Number 6. Sex	I ROAD  7. Age (In y	rs. last birthday)	SPARKS  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	BALTIMO	
*	Director		Usual Residence of Decedent  10a. State 10b. County	4	City, Town or Lo		1	IARCH 2		MARYLAND  10d. Inside City Limits
	th with the Marylan 23a or 28a-f ehow	Director	MD BALTIMOR  10e. Street and Number 2029 STRINGTOW		S	PARKS	1152	10	Og. Citizen of What Co	1 ☐ Yes 2 XNo
36	r deg	by Funeral Director		2. Was Decedent Ever in Armed Forces? 1 □Yes 2. No lf Yes, Give Year or Dates:			ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - Ame Black, Whit Specify: WH	e, etc.
21215-0036	within ene. than "	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work )	ing	16b. Kind of Business	
Maryland 2	iould be filed I Mental Hygi Parked other patic event, I	To Be C	17. Father's Name (First, Middle, Last) MARION ISAAC BA				18. Mother's Name BESSIE		faiden Sumame)	
	1 and 2 sh Health and em 27 ie n ther traun		19a. Informant's Name/Relationship (Typer BRADLEY MOORE 20a. Method of Disposition	executo	r 3112	PAPER I	MILL RD.	, PHEO	NIX, MD.	21131
Baltimore,	permit. Pages Department of Important: If it any injury or o	1	1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	1	MMANUE	natory or other place L CHURCI P. Name and Addres 16924	H 3/10/ ss of Facility HI	'2004 ENRY W.		MARYLAND & SONS CO
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		er the mode of dyin	g, such as cardiac o	or respiratory arre	ost,	Approximate Interval Between Onset and Death
760,	te be executed ysician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a con:	sequence of): UMGU	diomy or	parly		1540 2041s	
.O. Box 68	death certifica e attending ph id for use as It	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ic. If yes, outcome of pre  1 Live birth 2 F  4 Pregnant at time of the second	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
S, D	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the ur	nderlying cause give	en in Part I.		accoluse contribute to	o lhe cause of death?
Vital Record		Completed						24a. Was ar autopsy perform 1 Yes 2	prior to dealh?  ☐ No 1 ☐ Yes	topsy findings available completion of cause of 2 No
of	nding Physician: Tath. ath. r: After this certificat e funeral director, pa	ation: To Be	25. Was case referred edical examiner?  1  Yes 2 No  27. Manne Death  1  alural 5 Pending investigation	ospital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	at Nursing Ho		nce 6 Other (Spe	cify)
Division	e Hospital or Attending 24 hours after death. e Funeral Director: After etely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	ecify)			City or Town		
	To the Hospital within 24 hours a vithin 24 hours a completely filled	ledical	(Check only 2   Medical Examin	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, death ination and/or inv	vestigation, in my or	pinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To To con	Σ	29b. Signature and title of certifier	ND			7557		3/4/04	n, Uay, Year)
	10		30. Name and address of person who con	hlenoft	MO		718 Yor	KRD	MONTON	MD 21111
- 3	Sta Registi		31. Date filed (Month, Day, Year)  MAR 0 9 2004	32/Registrar's Si	Shailing A	enter				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 200<sup>4</sup>4 2:50 a<sub>M</sub> **Physician** 6, Joseph T. O'Connor /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Howard County General Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Day | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Maryland 214-14-4714 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ir then "natural", or Items 23a or 28e-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director MD. Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 9953 Frederick Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status s filed within 72 hours after de I Hygiene. other then "natural", or Item 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die maker Fabrication permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic aucon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph O'Connor Mary Rykowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine A. O'Connor/wife 9953 Frederick Rd. Ellicott City ,MD. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2004 Baltimore MD. New Cathedral Cem. 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Harry H. Witzke's Family F. H. Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 MOO845 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARTERY DISEASE Immediate Cause (Final disease or condition CURUNAL ONKHOWH Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by HVPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has filled in by the funeral director, page 2 autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medicai Certification; To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a

To the Funerel C

completely filled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and MARCH 8, 2004 completed cause of death (Item 23a) (Type, Print) 2465 Route 97 suite 10 Glenwood, MD. 21738 Dr.Scott Mauer 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

				1 State of Ma	ryland / Department of He		al Hygier	0001	07100
				Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of De		Reg. I	No. 2004	3. Time of Death
		Physic		IFONLARD	PAIRE	M		Day 2004	5:17pm
	1	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		11	4c. County ol Death	3
				IAMIZ	BAH.	imore		N/	A
0		Funeral Director		214-26-1600 1XM 20F		Hours Min. 8. Da	te of Birth onth, Day, Yea G-27,	9. Birthp	place (State or Foreign only) ARYLAND
d		iand ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	*		1	10d. Inside City Limits
ecnar		with the Maryland a or 28a-f show Le rolllied at	tor	MARYLAND NIA	DAI	TIHORE	= C1	TI	1, Yes 2 □ No
0		or 282	Director	10e. Street and Number	10f. Zip Code	-1 111012		Citizen of What Cour	ntry?
7		death wi		5303 ETHELBERT	AVENUE 2	1215		'USA	٠,
~	•	er de Hems	Funeral	11. Marital Status  12. Was Decedent E Armed Forces?	Il Yes, specify Cuban, I	anic Origin? (Specify Y Mexican, Puerto Rican,	es or No- etc.)	14. Race - Americ Black, White,	
S	-0036	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	1 □ Yes 2 No 5	Specify:		Specify: 2	AN W
	9-9	within 72 hours after ane than "natural", or Ite a Medical Examina		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	on	16b.	Kind of Business/In	dustry
177	21	d within 7 jiene. r than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5-		/			
(	12	77 6 5 7		12 HIGRADE	LONGSHORE				PTRADE
X	land	d ta b	Be	17. Father's Name (First, Middle, Last)		8. Mother's Name (First	Middle, Maid ⇒	0	= 0000/
a	2	2 should and Mer is marke sumatic	၉	19a. Informant's Name/Relationship (Type, Print)	PAIGE 19b. Mailing Address (Street and	17 Y / L   LC	Number Cit		EMAN
	Mary	nd 2 ilth a 27 is		BEATRICE PAIGE CWIF	1	-1 BERTAI	. 10		. 2/2/5
	altimore,			20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		Location - City or To	
	Ē	Page nent o ant: if ury or		1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  1. ☐ Donation 5 ☐ Other (Specify)	CEDAR HILL CEME	E. 13-09-	04 B	ALTIMARI	- MARYLAND
	Balt	permit. Pag Department Important: i any injury o		21. Signatu A Funeral Service Licensee	22. Name and Address of	of Facility Boncu	16 JR	FUNER	AL HOME
	_	& O E ₹ 0	1	MOWIN	21400	FULTON	AVE.	BALTO, A	10.21217
				23a. Fart1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line					Approximate Interval Between Onset and Death
		Pnysician /Medical		Immediate Cadse (Final disease - indition resulting in death)		ARCTIO	N .	1	Onset and Death
		Examiner		Due to (A as a	consequence of):				
			Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	consaquence olj:				
		kecuted and i-transit	Examiner	that initiated events C.					
	0,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last Due to (or as a	consequence of):				
	8760,	ate hys the	dlcai	d					
	9 X	requires that the death certificate be exeen signed by the attending physician hould be detached for use as the buria	Physician/Me	IF FEMALE: 23c. If yes, outcome o	Dregnancy	20.14	10		
	Вох	atter	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  25c. If yes, outcome of the pregnant at the past 12 months?  4 Pregnant at the pregnant at the	Fetal death 3 Ectopic pregnancy			23d. Date of delive Month	ry Day Year
	O.	that the deed by the detached	hysi	9 Unknown					
	S,	as tha gned oe det	by P	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in	in Part I. 23	e. Did tobacco	use contribute to th	e cause of death?
	ord	w requires that been signed to should be detail	led	Hyper tension			1 🗌 Yes	2 □ No 3 □ Proba	ably 4 Unknown
,	ecc	aw Is t	Completed by	END STAGE Renal	Disease	24	a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
X	Division of Vital Records, P.O.	(0 ===	Con	Diabetes		10	performed? Yes	death?	22 No
,	V:E	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?  1. Type: Add No. Hospital:	Others	6. Place of Death (Chec	Service Comments		
	o	Phys r this ral di	1: To	1 Inpatien	2 AE Outpatient 3 DOA	4 Nursing Home 5	Residence		)
	ion	Attending r death. ector: After by the fune	Certification:	27. Manner of Death  1		2 DNo	301100 11010 1111	ary occurred	
	Vis.	Attendi er death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	y - At home, farm, street, factory, office	281. Loc	ation (Street	and Number or Rural	Route Number,
		tal or rs afte ai Dir	Cert	Dulluling, etc.	(Specify)	Cit	v or Town, Sta	ite)	
		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	2 Medical Examiner: On the basis of e	my knowledge, death occurred at the time, oxamination and/or investigation, in my opinion	date and place, and due on, death occurred at th	to the cause(	s) and manner as sta	ated.
		thin 2 the 1 mplet	Med	one) and manner state 29b. Signature and title of a niles.	d. 29c. License nu				
		F 3 F 8		C Colones				ate signed (Month, L	
		6		30 Name and address of person who completed cause of dea	th (Item 23a) (Type Print)	1370	1 1 1	17(12011 2	1200
				FrEDERICK Burke	th (Item 23a) (Type, Print) TR, WO 2401 W.	Belvedene	Ave	BAltimo	Re, mo 21215
		Sta		31. Date filed (Month, Pay Year) 32. Registrar	s Signature -			130	
	1 4	Registr	ar	The state of the s	M Books				

			1 - For State Registrar	State of Ma	ryland / Dep Ce	partment of Health an ertificate of Death		ene 2004	07181
	Dhuaiai	8	1. Decedent's Name (First, Middle, La	st)			2. Date of Death Month	Dey Yeer	3. Time of Death
	Physici /Medio		Dwayne	Ler	oy	Pendelton	02	29 2004	06:13a <sup>M</sup>
è	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Location of D	Death	4c. County of Deeth	
			Good Samaritan	Hospital		Baltimore			
	Funeral		5. Social Security Number 6. S	Gex 7. Age	(In yrs. last birthda)	// If Under 1 Year If Under 24 Months Days Hours I	Min. (Month, Day,	Year) Cou	place (State or Foreign ntry)
	Director		215-76-2738 Usual Residence of Decedent	23.00	43 Yrs.		09 30	60	MD
	and		10a. State 10b. County		10c. City, Town or	_ocation			10d. Inside City Limits
	Mary f sho	ō	MEN NIZ		D = 1 + i				1 XYes 2 □ No
	the 286	Director	MD NA  10e. Street and Number		Baltim	10f. Zip Code	10	g. Citizen of What Cou	intry?
	Sa or		2045 7 11	7 70 7					
	ms 2	Funeral	2045 Ramblewoo	12. Was Decedent E	ver in U.S. 13	21239  Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	U.S.A. 14. Race - Ameri	can Indian,
9	or ite		1 ☐ Never Married 2X Married	Armed Forces?		17	uerto Rican, etc.)	Black, White,	, etc.
5-0036	ral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No Specify:		Specify: B.	lack
ည်	within 72 hours after death with the Manyland ene. than "natural", or items 23a or 28e-f show than "Neulcial Examinat must be notified at	Completed	15. Decedent's E (Specify only highest gra		16a. Dec	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	f working	6b. Kind of Business/Ir	ndustry
7	Athin han	du	Elementary/Secondary (0-12)	College (1-4or 5+	)				
7	filed w Hygier Sther ti		12th grade	na		leaning Servi		elf Emplo	oyed
and a	be fit ital H id otl	Be	17. Father's Name (First, Middle, Last,	,		18. Mother's	Name (First, Middle, Ma	aiden Sumame)	
3	should be filed within 72 hours after death with the Marylan Ind Mental Hygiene. Ind Mental Hygiene. Is marked other than *natural; or items 23a or 28e-f show marked other than *natural cavent, the Medical Franciar marked recitified at	၉	Leonard Pendel			Regin	a Thomas		
Maryland 2121	12 st h and 7 Is n traun	νi	19a. Informant's Name/Relationship (			ling Address (Street and Number of			
	1 and 1ealth 3m 27 ther tr	1	Gail Pendelton  20a. Method of Disposition	-Wile	204 20h Place of Dist	5 Ramblewood		timore Mode. Location - City or To	
٥	Pages nent of h ant: If ite ary or of	11-3	1 DBurial 2 Cremation 3		cemetery, cr	position (Name of sematory or other place)	Date 20	oc. Location - City of 1	own, State
altimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic once.		* 4 ☐Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lies	-		morial Park	3/4/04 R	andallsto	own, Md
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Lee	1380		22. Name and Address of Facility March F/H Wes	t		
			23a Part1 Foter the disease or com	inlications that save of	he death. Do not e	4300 Wabash A	ve, Balti	more Md	21215 Approximate
			23a. Part 1. Enter the disease or com shock, or heart failure List only Immediate Cause (Final						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	consequence of):	& Bridey !	Juseur	Qui.	124tale
	Examiner			Due to (or as a	consequence or):				
	*	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence of):				
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	c		•		1.	
o	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):				
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<u>.</u>	ing pl	Med	IF FEMALE:	15111-55-4-1001					
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o.	e deg the a	SIC	1 Yes 2 No	4□Pregnant at ti 9□ Unknown	me of death 5	Other (specify)		Monut	Day 18a
<u>.</u>	that the de led by the a detached i		Part II. Other significant conditions of	contributing to death but	not resulting in the	underhing cause gwen in Part I	23e Did toha	cco use contribute to the	he cause of death?
Records,	iires tha signed d be del	1 by	\$ 0 S		2000	lineira		2 <b>13</b> √ 3 □ Prot	
Ö	w require been sig should t	etec		A			_		
ě	has has	Completed					— 24a. Was an autopsy performe	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
								No 1 ☐ Yes	2 D No
Vital	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:	-/	04	Death (Check only one)		
ō	Phys rthis raldi	5	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Linpatien		ent 3 DUA 4 Nursir	ng Home 5 Residen		(y)
o	ding f h. After funer	tlon	1 □Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of Injury (Month, Day	Yeer) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. 50001150 1104	injury occurred	
Division of	Attendi death. ctor: A y the fu	flca	3 ☐ Suicide 6 ☐ Could not b	e One Diese of leive	y - At home, farm, s		28f. Location (Stre	et and Number or Rura	al Route Number.
2	after after Dire	Certification:	4 Homicide	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town,	State)	
	Hospitel or Attending Physicien: 44 hours alter death. Funeral Director: After this certificately filled in by the funeral director,		29a. Certifier 1 Certifying Ph	nysician: To the best of	my knowledge, dea	ith occurred at the time, date and p	lace, and due to the cau	se(s) and manner as s	tated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exer	niner: On the basis of e and manner state	examination and/or i	nvestigation, in my opinion, death of	occurred at the time, date	e and place, and due to	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	(0	00	29c. License number		I. Date signed (Month,	Dey, Year)
1	*		An Em	i i i	117	000172	12	3-2-04	L
	10		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)	261		. 0
			John E Hn	alwan	1 49	-24 Cambo	elo Bu	a Be	etimo
	Sta	te	31. Date filed (Month, Day, Year) 04 MAR 0 9 2004	32. Registrar	's Signature			21224	
100	Registr	ar	MILLIO D FOOT	3	" J"			- 7	

	1. Decedent's Name (First, Midd				Day Year 3. Time of D
Physician /Medical	Ronald Edw  4a. Facility Name (If not institution	vard Parker,	Jr.  4b. City, Town, or Location of I	MARCH	8 2004 03:37 4c. County of Death
Examiner	ST AGNE	11		ORE	N/A
Funeral	5. Social Security Number	6. Sex 7. Age (In yr	rs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	
Director	214-84-1642	XX M 2 3	Yrs. Months Days Hours	July 31,	1960 West Virgi
DO *	Usual Residence of Decedent  10a. State 10b. County	v 10c (	City, Town or Location		10d. Inside City
sho ed at			•		1∑ Yes 2
d within 72 hours after death with the Maryland speed. Then 'natural', or Items 23a or 28a-f show the Madical Examiner must be notified at completed by Funeral Director.	Maryland N/A	Dà	altimore 10f. Zip Code	10g.	Citizen of What Country?
3a or		oad	21229		USA
offer death virture 130 other must 34 other must 34 other must 34 other must 35 other	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No-	14. Race - American Indian,
or Its			1 ☐ Yes 2 ☑ No Specify:	ruerto moan, etc.)	Black, White, etc.  Specify: White
ural', o	3 Widowed 4 Divorce	d Year or Dates:			
ed within 72 hor ygiene. her than "natura t, the Wedical E Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired)	of working 16b	. Kind of Business/Industry
withing ane. than than	Elementary/Secondary (0-12)	College (1-4or 5+)	Customer Relation		G & E
a tiled with Il Hygiene. other than rent, the N				Name (First, Middle, Maid	
The second	Ronald Edward	Darkor Cr	Sara	E11a	Kellev
should nd Men marks umatic	19a. Informant's Name/Relation		19b. Mailing Address (Street and Number of		,
1 and 2 Health a tem 27 Is tem 27 Is	Ronald E. Park	er, Sr.(Father)	728 Bethnal Road, Ba	altimore, MD	21229
of Heritan	20a. Method of Disposition	20b	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c	Location - City or Town, State
Pages nent of nnt: It it ury or o	1 Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (	2 Pueuro Agrana Prarie	oudon Park Cemetery 3	/11/04 Bal	timore, Maryland
permit. Pages Department of h Important: If its any injury or of	21. Signature of Funeral Service		22. Name and Address of Facility	Loudon Park	Funeral Home
89689	1/1/		3620 Wilkens Ave	e., Baltimore	
	23a. Part 1 Enfor the disease, of shock, or heart failure. Lis	or complications that caused the de it only one cause on each line.	eath. Do not enter the mode of dying, such as ca	irdiac or respiratory arrest,	Approximate Interval Betwe
hysician	Immediate Cause (Final disease or condition	. End Sta	age Renai Diseo	se	Onset and De
/Medical xaminer	resulting in death)	Due to (or as a conse		,-	7
Kallilliel		b			
- N	Sequentially list conditions,	Due to for an a seen			
nsit niner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury)	Due to (or as a conse	equence of):		
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in 24 hours after death.  he Funeral Director: After this certificate has been signed by the attending physicial pletter. After this certification, page 2 should be detached for use as the bur pletely filled in by the funeral director, page 2 should be detached for use as the bur pletely filled in by the formula form	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a const d.  23c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time of 9   Unknown  ions contributing to death but not re  al Hospital: 1   Inpatient 28a. Date of Injury (Month, Day Year)  ing ing ing ing ing ing ing ing ing ing	gnancy stal death 3   Ectopic pregnancy of death 5   Other (specify)    sulting in the underlying cause given in Part I.  26. Place of Other: 4   Nursi 28b. Time of Injury M   28c. Injury at Work? M   1   Yes 2   No cify)  shome, farm, street, factory, office  conversely   29c. License number    2	1 Yes  24a. Was an autopsy performed 1 Yes 2 1 1 1 Yes 2 2 1 1 Yes 2 2 2 2 2 2 2 3 2 3 2 3 2 3 2 3 2 3 2	Month Day Yes  to use contribute to the cause of deal 2 No 3 Probably 4 Unit  24b. Were autopsy findings aviority to completion of cause death? No 1 Yes 2 No  6 Other (Specify)  njury occurred  and Number or Rural Route Number ate)  o(s) and manner as stated, and place, and due to the cause(s)

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cm	1 _ For	State of Maryland / Department of Heal Unpend ITem#23a,27,28a-f,Per ME,0829,3/22/0498

**Physician** /Medical Examiner

**Funeral** Director

28a-f show the Medical Examiner must be notified at ŏ or Items 23a within 72 hours after 'natural' marked other than

Maryland 21215-0036 permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If itam 27 is marked o ō injury any Physician /Medical Examiner

Baltimore,

Box 68760,

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Records,

Division of Vital

Examine death certificate be executed and burialphysician Physician/Medical the as esn ō the The law requires that the ģ Completed peen has page certificate director Be 2 this funeral Certification: After Hospital or Attanding death. the Director filled in by after

alth and Mental Hygiene Reg. No. 2004 Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Petrillo Adam Roberts 10:30 P M February 29, 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Near East Diamond and North Summit Gaithersburg Montgomery If Under 1 Year | If Under 24 Hi Months | Days | Hours | Mi 8. Date of Birth Month, Day, Year, MAY 15, 1973 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Min. 1 XM 2 □ F 30 218-15-5395 Washington DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 8202 Pleasant Plains Road **USA** Funerai 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 XNo Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 Wood Working 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Albert Steven Petrillo Sandra Kay Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Kay Roberts/Mother 8202 Pleasant Plains Road Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-5-04 Baltimore, MD 21. Signature of Euperal Service Lightsper / Thomas Gregor / Cremation Society of MD, 299 Frederick koad Ba Inc. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? 1XYes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2/29/04 1 ☐ Yes 2 🕱 No unknown investigation found10:156 2 Accident 6x Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide railroad tracks E.Diamond and N. Summit, Gaithersburg, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 01, 2004 30. Name and address of person who completed causes death (Item 23a) (Type, Print) Toll JONICA. ALTII Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

0 9 2004

within 24 hours a To the Funeral D

parks

32. Registrar's Signatura

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Merch 4, 2004 Mary E. Ray **Physician** 8:30 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Laurel Regional Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 84 Yrs. 8. Date of Birth (Month, Day, Year) August 10, 1919 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Washington, D.C. 219-16-1343 Yrs. Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Capital Heights 1X Yes 2 □ No Prince George's Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20743 6904 Seat Pleasant Drive Apt.#302 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced \*naturel\* Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Domestic Housewife 11th grade 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event QDEs. 17. Father's Name (First, Middle, Last) Carrie Smith Frank Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6904 Seat Pleasant Drive Capital Heights, Maryland 20743 Apt.#32 19a. Informant's Name/Relationship (Type, Print) Carrie Ray (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) March 12,2004 Washington, D.C. Mount Olivet Cemetery 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HINT PLACE, N.E. WASHINGTON, D.C. 20019 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Premonia /Medical Due to (or as a consequence of) Examiner Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Sepsis
Due to (or as a consequence of): attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dysphagia been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed? Yes 22 No 2₹ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral i 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Haylend Attending. D42580 March 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.S. Aujla, M.D. Attending 5632 Amapolis Road #13 Bladensburg, Maryland 20710 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 9 2004

DHMH 17 Rev 1/2001

Ren. 8/10/1915.

			For State Registrar	State of Ma	ryland /		artmen tificate					iene g. No. 2	004	071	185
	Physic /Medi		1. Decedent's Name (First, Middle, Las						RI	99	2. Date of Deat Month MARCH		Year Z004	3. Time of 14:10	Death M
1	Exami	ner	4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·	<b>-</b>		-		Location o		/	4c. Co	unty of Death		
	Funeral	P	THE JOHNS HOPK  5. Social Security Number  6. So	INS HOSPI	(In yrs. last b	irthday)	BAL. If Under		If Under:		8. Date of Birth		n/a	place (State or	r Formian
	Director		214-30-4954 Usual Residence of Decedent	TM 2KTF	70	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, March 2	<sup>Year)</sup> 19	Cour	ryland	
	d within 72 hours after death with the Maryland Jiene. I than "natural", or Items 23a or 28a-f show Itte Medical Examiner must be notified at	_	10a. State 10b. County		10c. City, Tov	wn or Lo	cation						1	0d. Inside Cit	
	28a-f	Directo	Maryland Balt	imore	T	imor	nium							1 🗌 Yes	2∏No
	with Ba or		414 Rockfleet Road	l			10f. Zip	Code 2109	2		10	-	of What Cour	ntry?	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ev		13. V				gin? (Spe	ecity Yes or No- Rican, etc.)	US.	A Race - Americ	an Indian,	
36	or ite		1 ☐ Never Married 2 🂢 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1	Yes, speci		n, Mexican Specify:	, Puerto	Rican, etc.)		Black, White,	etc.	
Maryland 21215-0036	hours tural',	ed by	3 Widowed 4 Divorced	Year or Dates:	10-									ite	
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nd	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle, M				
Zla	2 should be and Mental Is marked (	2	Lester Howard							olin			Baker		
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	s 1 an f Heal item 2		Helmut Rigg/Husba 20a. Method of Disposition	ilia	20b. Place o	of Dispos	sition (Name	e of			it 303,		nium, I on - City or To		193
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☑ Other (Specify)		1		natory or oth			/8/0	4				
alti	permit. Page Department Important: It any injury or once.		21 Signitur of JuneauSalVice Licar		bullun	22.	Name and	Address	of Facility	/	C D 1		onium,		ına
	20 E 2 9			mon	VILIY	$\top 10$	) W. I	2adoi	nia R	oad.	of Dula Timoniu	m. M	Valley D 2109	Inc. 93	
	Physician /Medical Examiner		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. METASTA  Due to (or as a	TIC NOT	1-Si								Approximate Interval Betw Onset and De YEAL	eath
8760,	rcate be executed physician and sthe burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c			<i>*</i>								
387	physicate physicate	dica		d											
P.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death		Ectopic pre Other <i>(spec</i>						Date of deliver Month	ry Day Ye	ar
σ.	s that I	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in	n the un	derlying cau	ise giver	n in Part I.		23e. Did toba	cco use co	ontribute to the	e cause of dea	ath?
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eco	law re as be 2 sho	Completed									24a. Was an	24	b. Were autop	sy findings av	railable
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Vita	ician: The la certificate has rector, page 2	Be	25. Was case referred to medical examiner?	lospital:						of Death	(Check only one)				
ō	Attending Physician: r death. ector: After this certifics by the funeral director, g	<u>۲</u>	1 ☐ Yes 2 📉 No 27. Manner of Death	1 2 Inpatient	2 ER/Ou	tpatient Time of			4 🗀 Nurs		e 5 ☐ Residen				
O	ding I th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	ear)	njury	M	injury a Work?	at es 2.⊟N		8d. Describe how	injury occ	curred		
	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, fa (Specify)	ırm, stre	et, factory,				8f. Location (Stre City or Town,	et and Nur State)	mber or Rural	Route Numbe	er,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of oner: On the basis of exand manner states	tamination an	d/or inve	occurred at estigation, in	the time	, date and nion, death	place, a	nd due to the cau d at the time, date	se(s) and a	manner as sta e, and due to t	ted. the cause(s)	
	To th Comp	Me	29b. Signature and title of certifier				29c. t	License	number		290	. Date sigr	ned (Month, D.	ay, Year)	
	. 10		John M.	3.			1	16	702		M	ARCH	04,2	2004	
	10		30. Name and address of person who co	ompleted cause of deal	h (Item 23a) (	(Туре, Р	rint)	C	7 5	0 ^					
	Sta		AYOUELE ELINCE A  31. Date filed (Month, Day, Year)	(1) 401 NO 32 Registrar's		CAD	TAY	STRI	tet,	<b>BA</b>	LTIMORE	)VI	0 212	231	
	Registr		MAR 0 9 2004	Sz. Registial		1000									

\$ m		State     Registrar     Decedent's Name (First, Middle, Las	t)		ertificat	e of L	Jeath		2. Date of Dea			3. Time of Death	6
Physici /Medi		Aisha Sharif							March		2004	3:00a <sub>м</sub>	
Examir	ier	4a. Fecility Name (If not institution, give 6002 B Linganore			4b. City, Fred		Location o	of Death			ty of Death		
Funeral Director		Social Security Number 6. S		(In yrs. last birtho	(ay) If Under		If Under Hours	Min.	8. Date of Birth (Month, Day Aug 10	, <sub>Year)</sub> 1942	9. Birth Cou	place (State or Foreign intry)	7
Maryland -1 show	tor	Usuel Residence of Decedent  10a. State 10b. County  Md Freder		Freder								10d. Inside City Limits 1 ☐ Yes 2 No	
with the 3a or 28a	Funeral Director	10e. Street and Number 6002 B Linganore	Road		10f. Zip	Code 1701				10g. Citizen o		intry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlib and Mental Hygiene. Department of Heatlib and Mental Hygiene. The Marylant: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination molified at an any injury or other traumatic.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Novorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	er in U.S.	13. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	Bt	ace - Ameri lack, White eify: Whi	, etc.	
within 72 houene. Then "neture the Medical E	Completed	15. Decedent's Ec (Specify only highest gra			ecedent's Usua Bive kind of wo fe. DO NOT us vellnes				ng	16b. Kind of healt		-	
od 2 should be filed the and Mental Hyg 27 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Allan Volk		. 1					(First, Middle, usbaum	Maiden Suma	ame)		
od 2 sho Ith and N 27 is ma trauma		19a. Informant's Name/Relationship (19a. Ruqaiya Asad (daug	· · · · · · · · · · · · · · · · · · ·						Route Number Frederi				
oermit. Pages 1 an Department of Heal mportant: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of D cemetery, Lake V	crematory or o	ther plac	1 3	D-8-04		20c. Location Sylvesv			
permit. Departm Importa any inju		21. Signature of Funeral Service Licer Page Haight 3							ght Fun ille, M			Chapel	
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	a. HEPA	TOMA				cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death 2 YEADS	
/Medical Examiner		resulting in death)	h	consequence of)		IVE	2					YEARS YEARS	
be executed sicien and burial-transit	I Examiner	Ecquentially letter uniformediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. HEPP	consequence of)	C	***						YEARS	_
The law requires that the death certificate be eath as been signed by the attending physicien age 2 should be detached for use as the burit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	d	Fetal death	3 □Ectopic p 5 □ Other (sp						Date of delive	very Day Year	
juires that n signed b	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the	ne underlying o	ause give	en in Part I	l.	23e. Did to 1 □ Y	~		the cause of death? bably 4 □Unknown	1
aician: The law requires! certificate has been signe irector, page 2 should be	Completed								24a. Was a autop perfor 1 ☐ Yes	sy		opsy findings available ompletion of cause of	,
ing Phyaician: After this certific uneral director,	To Be	25. Was case referred to medical examiner?  1  Yes	28a. Date of Injury (Month, Day	t 2 ER/Outp 28b. Tin Year)		28c. Injun Worl	er: 4 🗆 Nu	ursing Hon 2	(Check only or ne 5  Resid 8d. Describe h	ence 6		ity) SON-IN-LA	N
after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm (Specify)				<u> </u>	8f. Location (S City or Tow		nber or Rui	ral Route Number,	
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C		ysician: To the best of niner: On the basis of e and manner state	examination and/									
To th withir To th comp	Me	29b. Signature of title of certifier	O Brings	MO		D	e number	61		29d. Date sign	6/04		
()		30. Name an address of person who	completed cause of de	4	/pe, Print)	SEIN	ENTH-	- 67	CAC	NERIO	4 1	(D 2170)	1

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State o	of Maryla	and / Dep <i>Ce</i>	artmen rtificate			and M		~	2004	07187
	Physici		1. Decedent's Name (First, Middle, Last, Glenn Mi		Shaw						2. Date of De Month March		2004 Year	3. Time of Death 7:30pm M
Î	/Medic Examin		4a. Facility Name (If not institution, give 5710 Oak View Dri		imber)				Location o			4c.	County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 15.	M 2□F	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da Feb. 7,	y, Year)	9. Birthe Cour . 8 MI	place (State or Foreign htry)
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County  MD Carrol.	1	10c.	City, Town or Lo		cesv:	;110				1	0d. Inside City Limits 1 ☐ Yes 2 📆 No
	ith the Mi or 28a-f	Directo	10e. Street and Number	_			10f. Zip	Code				10g. Citi	izen of What Cour	
336	2 should be filed within 72 hours after death with the Maryland and Menth Hygiens. Is marked other than "natural", or items 23s or 28s-1 show asmalic event, its Madical Examinational bandilled at	by Funeral Director	5710 Oak View Dri  11. Marital Status  1 Never Married 2 Married  3 NWidowed 4 Divorced		2 □ No ive t.7	u.s. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	784, spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	•	USA 14. Race - Americ Black, White, Specify: Whit	etc.
Maryland 21215-0036	within 72 hou ene. then "nature re Modical E	Completed	15. Decedent's Edu (Specify only highest grad			(Give	dent's Usua kind of wor DO NOT us Sk Ser	k done d e retired,	luring mosi )	t of workin	ng		nd of Business/Ind	·
land 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Arthur Shaw				on bei	gear	18. Mothe		(First, Middle,	Maiden		mene
	and 2 sho ealth and t n 27 is me		19a. Informant's Name/Relationship (Ty Mr. Michael Shaw				•						r Town, State, Zip ID 21784	Code)
altimore,	of High		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from		o. Place of Dispo cometery, cre ake View					ate 2004		cation - City or To	
Balti	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Licens	Ha	ist						-	-	PA (Box -1400	
100	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on	each line.	C MEL			, such as	cardiac o	r respiratory ar	rest.		Approximate Interval Between Onset and Death
8760.	E xaminer second disciplination and point principle of principle principles of the contract of	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhein, Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a cons	sequence of):								
.O. Box 6	that the death certifical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live	itcome of pre birth 2 F nant at time of	etal death 3	Ectopic pre						23d. Date of delive Month	ory Day Year
S, O	quires that the signed by ald be detac	by	Part II. Other significant conditions co.	ntributing to d	leath but not	resulting in the u	nderlying ca	iuse give	in in Part I.			obacco u 'es 2[		abiy 4 (4) (4) (4)
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Vita	Physician: The l this certificate har ral director, page	To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	Inpatient 2	ER/Outpatie	nt 3 DO	A Othe			(Check only o	pe)	5 ☐ Other (Specify	(1.5-1)
Division of Vital	Jing Ph J. After th funeral		27. Manna of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date		28b. Time o		Bc. Injury Work		2	8d. Describe h			
Divis	in Sir de	Certification:	3 Suicide 6 Could not be determined	28e. Place build	e of Injury - A ling, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory	, office		2	8f. Location (S City or Ton		d Number or Rura )	l Route Number,
	To the Hospital within 24 hours a To the Funeral completely litled	edical	29a. Certifier 1 Certifying Phy (Check only one)	ner: On the b	e best of my loasis of examiner stated.	knowledge, deat iination and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the old at the time.	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
)	To th To th compl	Me	29b. Signature and title of certifier	_			29c.	License	number 2806		1	29d. Dat	e signed (Month, i	Day, Year)
	6		30. Name and address of person who co	LNS 6	se of death (I	Item 23a) (Type,	Print)	-		- LON	SRULG	an)	21784	
7	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 200	30	Registrar's Si	Item 23a) (Type, 1000 L/					b			

		_	For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of He	ealth and M Death	lental Hygi	ene 200	4 07188
	Physicia	an	1. Decedent's Name (First, Middle, Last		s, Sr.			2. Date of Death Month March 7	) Day Year	3. Time of Death 12:55p M
1	/Medic Examin		4a. Fecility Name (If not institution, give Carroll Hospita	street and number)	,		minster		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Set 1/215-26-9476 X  Usual Residence of Decedent	x 7. Age (	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 9	Year) C	thplace (State or Foreign ountry)
	Maryland a-f ahow iffed at	tor	MD 10b. County Carrol		10c. City, Town or Lo Sykes					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	vith the	Direc	10e. Street and Number			10f. Zip Code	2.4	10	og. Citizen of What C	ountry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23s or 28s-f show other traumatic event, the Medical Expresser must be notified at	l by Funeral Director	6909 Springhill D  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	AMALT I	2178 Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	USA  14. Race - Am Black, Whi	
21215-0036	within 72 ho iene. • then "netur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done do DO NOT use retired) fic & Ware	uring most of work	ing	16b. Kind of Business $ ext{Mill}$	Vindustry
Maryland 2	d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then " traumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) Fred Stiles				18. Mother's Nam Esti	e (First, Middle, M e Clark	faiden Sumame)	
Mary	d 2 sho lith and h 27 is ma trauma	·	19a. Informant's Name/Relationship (7 Mrs. Willie Hyder						City or Town, State,	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo			Date 2	20c. Location - City or Sykesville	Town, State
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	Hais &	. H	AIGHT FUNI Sykesville	ERAL HOME , MD 217	E & CHAPE '84 (410)	EL, PA (Bo 795-1400	x 195)
*	Physician /Medical		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	st,	Approximate Interval Between Onset and Death					
8760,	executed shakes and shakes and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	00005	Pne	TWOU	La	
O. Box 6	death certific e attending p id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
α.	es be	ed by Ph	Part II. Other significant conditions of	entributing to death but	not resulting in the	underlying cause give	n in Part I.			o the cause of death?
Division of Vital Records,	The law ate has b page 2 si	Completed by	Acrete Re	nol d	aille	re!		24a. Was ar autops perform 1 \sum Yes 2	y prior to	
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	2 C EB/O	ot 3 DOA Othe		h (Check only one		
ion of	ding After fune	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	28b. Time o	of 28c. Injury Work	4   Indising the		nce 6 Other (Spew injury occurred	ecity)
Divis	E Dit	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or F i, State)	lural Route Number,
	ne Hospitel	edical		ysician: To the best of liner: On the basis of e and manner state	examination and/or in					
	To the vithin 2 To the comple	Σ	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Mon	th, Day, Year)
	5		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print) S	25052 wite 1	02	STILD	MD 2017
	Sta Regist	ate rar	31 Date filed (Month, Day, Year) MAR 0 9 200	36. Registrar	's Signature	sales	ve, U		14142)	THE ATT

MHV			1 - For State Registrar Unpend ITem							ind N	lental Hy	giene	000	) l <sub>4</sub>	071	0.0
	Physic		Decedent's Name (First, Middle,     James Soul		Litter 11	3,0029,0	hadone	<u> </u>			2. Date of De Month MARCH	ath Da	,	rear	3. Time of D	
	/Medi Examii		4a. Fecility Name (If not institution, 603 GOODMAN AV	•	nber)		4b. City, To	own, or		f Death		40.	County of			<u> </u>
3299	Funeral Director		5. Social Security Number 215-90-3750  Usual Residence of Decedent	3. Sex 1 1 M 2 □ F	7. Age (In yrs.	last birthday) 27 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Jul 25	th ly, Year) , 19	76	9. Birthpla Count Mary	ace (Stete or I ry) and	Foreign
	e Maryland 8s-f ahow	Director	10a. State 10b. County MD Harfor	·d		ty, Town or Lo l Air	ecation							10	d. Inside City	
	23a or 2	ai Dire	3131 Nova Scotia	a Road			10f. Zip C 2101						izen of Wr ted S		,	
036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ahow ha Nedical Examinat must be invilled at	by Funeral	11. Marital Status  1 Meever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 ⊠No e		Was Deceder f Yes, specify		panic Orig , Mexican, Specify:	in? (Spe Puerto	ecify Yes or No Rican, etc.)		14. Race Black, Specify: W	White, e	tc.	
Maryland 21215-0036		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		4or 5+)	(Give life. L	dent's Usual ( kind of work DO NOT use Washe	done du retired)	ion uring most	of worki	ing	16b. Ki	nd of Busi	ness/indu	istry Trucki	ng
ryland	should be filed and Mental Hygi markad other umatic event, I	To Be C	17. Father's Name (First, Middle, La William James S	oul					Pauli	ne 1	e <i>(First, Middl</i> e, Patrici	a St	acey			
, Mai	and 2 sh lealth and m 27 ls n		Ms. Janine Bruc	. , , ,		3131	Nova S	Scot		ad,	Bel Ai				Code)	
Baltimore,	Pages 1 ment of H ant: If ite ury or oti		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  '4 □ Donation 5 □ Other (Spe		tate	Place of Dispo- cemetery, cren Lesapea	natory or othe	er place,	1	M	lar 9		cation - Ci			
Ball	permit. Departs Imports any inj.		21. Signature of Funeral Service Li	U M	2800	8	3717 G	reer	Past	ture	ral Alt	e Ba	ative altim		MD	
8760,	Physician /Medical Examiner  physician and physician and the prujal-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, isability to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	or as a consequent as a consequent as a consequent	uenca Uf).	(Cocarne	e amo	i Oxycc	odone					Onset and Dea	
P.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	Ideath 3	Ectopic pregr Other <i>(speci</i>					2	3d. Date o		ay Yea	ar
	v requires that been signed t should be det		Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the un	derlying caus	se given	in Part I.		23e. Did to				cause of deat	
al Records,		e Completed	25. Was case referred to medical					-				sy med? 2 🗖 No	prio dea	r to comp th?	y findings ava letion of caus	se of
Division of Vital	hysicie his cerl I direct	Certification: To Be	27. Manner of Death  1 □ Natural  2 □ Accident  3 □ Suicide  5 □ Could not	bo	Injury Day Year)	EP/Outpatient 28b. Time of Injury 11:55a	28c.	Other: Injury a Work? 1 \( \subseteq Ye	4 🗌 Nurs	ing Hom	(Check only or ne 5 Reside 8d. Describe h	ence 6	X Other (	Specify)	SCENE	
Divi	Hospital or Attende 14 hours after death Funeraf Director; tely filled in by the		4 Homicide determine	found: r	esidence	9				60	8f. Location (S. City or Town  3 Goodina  4 Limore d	n, State) n Ave	nue,Du	ndalk		;
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	Physician: To the bas aminer: On the bas and manne	is of examinat	ion and/or inve	estigation, in	my opin	ion, death	occurre	d at the time, d	late and	place, and	due to th	e cause(s)	
	T William T		29b. Signature and title to certifler	July .	M			cense n					signed (M H 8,			
	206a		30. Name and address of person wh	AN				Pen	n Str	reet	, Balti	more	, Mai	ylar	nd 2120	01
nji	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 9 20		gistrar's Signat	ure for	les .									

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of h	lealth and Death		giene2 () Reg. No.	104	07190
	Physici	an	1. Decedent's Name (First, Middle, Las		STOK	KES		2. Date of De Month MAIZO		Yeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		-101		or Location of Deat			ty of Death	( S)
	LAGIIII			our		BAL	TIMOR	2e	1	V/A	
	Funeral Director		5. Social Security Number 6. S 215 16 9169	ex 7. Age (In yrs.	last birthday) Yrs.	Months Days			th ay, Year) +121	9. Birthp Coun	lece (State or Foreign htry)
-	יס		Usual Residence of Decedent	1100.00					11-1	1	Od. Inside City Limits
	Aarylau f ahow	or	10a. State 10b. County		ty, Town or Lo	nore				,	1 ∑Yes 2 □ No
	or 28a-	Director	10e. Street and Number	1		10f. Zip Code			10g. Citizen o		ntry?
	ath wil	ral		e Avenue	10 42		21223	Considu Vos or No		1SA	en Indian
(0	r Item	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ▼Yes 2 □ No If Yes, Give	1	_	Hispanic Origin? (S ean, Mexican, Puer	to Rican, etc.)		lack, White,	etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Itame 23s or 28s-f show event, I're Medical Exarting must be rediffed at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 Yes 2 No			Spec		
15-	in 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	nking	16b. Kind of		,
	filed within Hygiene.	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Sta	tional	Engine	eer		icati	on
Maryland		Be	17. Father's Name (First, Middle, Last,	UNK				me (First, Middle OVET			
aryl	2 should be and Menta is marked aumatic ev	To	19a. Informant's Name/Relationship (		19b. Maiti	ng Address (Street	and Number or H				Code)
	s 1 and 2 should if Health and Mer item 27 is mark other traumatic		2011	Les/WIFE	2210	o Penro	ose Ave	nueB	alfino 20c. Location	re M	D 21223
nore	Peges 1 nent of H ant: If its ary or of		20a. Method of Disposition  1 ★Burial 2 ☐ Cremation 3 ☐  4 ☐ Donetion 5 ☐ Other (Specif	Bemoval from State	cometery, crei	matory or other pla	100)	19/04			LS MD
Baltimore,	permit. Peges Department of Importent: If it any injury or once.		21. Signature of Funeral Service Licer		2	2. Name and Addre	ess of Facility VC	rugher C.	Greene	Funa	al services
8	88 28		V Cough C		5	51 Baltin	nore Nat	ional Pil	ke Balt	imare	MD 21229 Approximate
	<b>D</b> iscontinuo		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1./20	er the mode or dy	ng, such as cardia	ic or respiratory a	rrest.		Interval Between Onset and Death
11/2	Physician /Medical		disease or condition resulting in death)	Due to (or as a cope	quen <i>ce of</i> ):	(M)C					39600
	Examiner	-r	Sequentially list conditions,	b. Due to (or as a conse	quence of):			,			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
90,	ate be executed nysicien and he burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
68760	icate phy s the	Physician/Medical	•	d							
Вох	ath certif attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		⊒Ectopic pregnand	:y			Date of delive	ory Day Year
.O. E	it the death by the atte tached for	yslci	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5[	Other (specify) _					July 100
<u>α</u>	es that thighed by	by Ph	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	inderlying cause gr	ven in Part I.	23e. Did (	lobacco use co	ntribute to th	ne cause of death?
ord	w require been sig should b							10		3 🗌 Prob	
Records,	ne law s has b ge 2 sl	Completed							psy ormed?	prior to cor death?	psy findings available impletion of cause of
Vital		Be Co	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only	2 No	1 🗆 Yes	2□ No
of V	Physician: r this certifica ral director, I	2	examiner?		ER/Outpatie	III JU DON		Home 5 Resi			у)
	ding F th. : After funer	tlon:	27. Manner of Death  1. Anatural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	iryat ork? ]Yes 2 □No	280. Describe	how injury occi	11190	
Division	r Attending er death. rector: Afte i by the fune	Certification:	3 Suicide 6 Could not be determined			reet, factory, office			Street and Nun wn, State)	nber or Rura	l Route Number,
Q	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a, Certifier Certifying Ph	nysician: To the best of my kn	nowledge deat	h occurred at the t	ime, date and place	e and due to the	cause(s) and r	manner as s	tated
	ne Hos n 24 ho na Fun oletely	Medical	(Check only 2 Medical Example)	miner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place	and due to	the cause(s)
	Withi To th	Σ	29b. Signature and title of certifier	212 . 1 . 1		^	se number		29d. Date sign	ed (Month,	Day, Year)
	1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Tvoe	Print)	6529		5/2/	200	<i>J</i>
	\		PAYL CELANS	, NO 651	9 N.C	Charles -	XT-#265	BACT	noy N	DZI	204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	arte					

	_	State Registrar					ind / Depa	rtificat	e of L	Jealii			Reg. No.		0 7	0719
	1. De	ecedent's Name	e (First, Middle,	Last)								2. Date of D Month	Day		Year	3. Time of Death
ian ical		HELM					OCK HE					march		/	2004	1700 P
ner	4a. F	ecility Name (I	f not institution,	give stree	et and num	iber)				Location of			4c. (		of Death	-25
ð.		MORTITU			SPITA		rs. last birthday)	1.00	-	If Under 2		Date of B	irth	13/4		ace (State or Forei
		cial Security N 2–40–28	umber (	6. Šex ∓⊡ M	2 F	7. Age (iii yi 82	Yrs.	Months		Hours	Min.	(Month, C	$\frac{p_{ay, Year}}{192}$	1 0	Germa	tru
		2-40-20 al Residence of				02				1			,			
		State	10b. County			10c.	City, Town or Lo	ocation							10	0d. Inside City Limit
by Funeral Director	Man	ryland	Baltim	nore				L	oche	arn						1 ☐ Yes 2 N
į	_	Street and Nur	mber			·		10f, Zip	Code						hat Coun	-
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	11. N	Marital Status			Armed For		U.S. 13.	Was Deced	dent of Hi cify Cuba	ispanic Orig in, Mexican,	n? (Spec Puerto R	ify Yes or Nican, etc.)		Black	e - America k, White, e	etc.
		☐ Never Marri	ied 2 Marne	ed	1 ☐ Yes If Yes, Give	е		1 🗆 Yes	2 XNO	Specify:				Specify:	Whit	e
	3			a Educati	Year or Da	ites:	16a Dece	dent's Usu	al Occupa	ation			16h Kin	d of Bu	siness/Inc	lustry
			15. Decedent's cify only highest	grade co	ompietea)		(Give	kind of wo	ork done d	during most	of working	7	100.14			,
	Ele	ementary/Seco Unkr			College (1-	-4or 5+)	Baker						Bake	ry	Busir	ness
	17. F		(First, Middle, L	ast)						18. Mother	s Name (	First, Midd	le, Maiden	Sumame	e)	
ממח					unkno	own						unl	nown			
0	19a.	. Informant's N	ame/Relationsh	ір (Туре,	Print)		19b. Maili	ng Address	s (Street a	and Number	or Rural	Route Num	ber, City or	Town, S	State, Zip	Code)
	Gi	na Coop	per				6811	Camp	otiel	d Rd.	<b>,</b> ва.	Ltimor	re, ML	) 21.	207	
		Method of Dis				1	. Place of Dispo	osition (Nai	me of other plac	(e)	Da	te	20c. Loc	cation - (	City or To	wn, State
			☐ Cremation 5 ☐ Other (Sp		oval from S	State   W	lood1awn				arch	6, 20	004 Wc	od1	awn,	Maryland
			uneral Service L	icensee												Directors
		1 Jan	shy t	ell	ner !	1003	33 87	28 Li	ibert	v Rd.	Rai	ndall:	stown,	MD	2113	3-4784
	23a	Dar Enter	1 11							,						
		t. Pierri. Lintor	e disease, or o	complicat	tions that ca	aused the de	eath. Do not en									Approximate
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State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND ITEM #9&12 PER FH G829 3/30/0 Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MACH LEWIS CONRAD SMITH /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OVER RIDGE CT. N/A BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 TEXAS 7. Age (In yrs. last birthday) **Funeral** Hours Days 484-28-8538 1 M 2 □ F 89 Yrs. Director <del>MEXIC</del>O Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 28a-f show Director 1 Yes 2 No PA. LANSDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3406 BRITTANY POINT 19446 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 22 And XY Yes 22 And Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is markad other than any injury or other traumatic event, that once. EDUCATION ENGLISH PROFESSOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEWIS C. SMITH ٩ CLARA B. PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY E. SMITH(WIFE) 3406 BRITTANY POINT LANSDALE, PA. 19446. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY 03/09/04 BALTO CITY, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility &\_SONS\_CO. HENRY W. **JENKINS** Willianke 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Arteriosclerotic Cardiovascular Visease D Y29/5 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of): Physician/Medical use as t attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 the 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 5 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Be Completed 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page certificate 1 ☐ Yes 2 🔀 No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ▶ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 2 Accident Injury 5 Pending investigation within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 22 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 30. Name and address of person who completed cause of death (Item 23a) (Tyw., Print) PHILIP MILITELLO M.D. TRIMBLE HILL CT. LUTHERVILLE, MD. 21093. 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

**Physician** /Medical Examiner **Funeral** 

Director

Show r 28a-f show r than "natural", or Items 23a or the Medical Exeminer must be within 72 hours after nd Mental Hygiene. marked other than permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any injury or other traumatic event 9088.

Physician /Medical Examiner

Baltimore,

The law requires that the death certificate be executed tran and attending physician a for use as the burial O. Box 68760 the as ed by the a signed l Records. Division of Vital To the Hospitel or Attending Physicien: After this funeral of death. Director: in by the

within 24 hours after d To the Funeral Direct completely filled in by

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 23a, PtI per ME,G829,03/09 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 200 Ly 07193 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 8:04 AM 25, 2004 Lebrua CYNTHIA SORILLO 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bultimore Baltrudre Sinai Hospital 10 If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 11-3-1937 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours Trinidad 1□M 2√2F Yrs. 217-64-5345 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Director Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 Funeral 3812 Hayward Ayenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) N/A Rosewood State Hosp Nurses Aide 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jenita Sydney Anthony Reyes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21215 4019 Grantley Road Balto. Md Hilda Sorillo - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 3-6-2004 Balto, Md 14 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Avenue Balto, Md 21215 mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ailure Days Kenal Due to (or as a consequence of): Accident Day Motor Vehic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď Lobe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 A No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 № Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 2 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27 Manner of Death Certification: 5 Pending investigation 1 Natural Colliston 1 ☐ Yes 2 No vanuary 29,204 Notor Vehicle 7:01 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES- OOO Ma -, HD March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND ear) 32. Reg MICHELE 31. Date filed (Month, Day, Year) State MAR 0 9 2004 . Regional

State of Maryland / Department of Health and Mental Hygiene 2014 For State Registrar Certificate of Death Reg. No 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Calvin Ε. Staten 1:00 a M 1 2004 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto 10 Valdivia Ct Randallstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-18-1943 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1<del>⊊</del> M 2□ F 60 Yrs. N.C. Director 240-66-4618 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23a or 28a-f ehow other traumatic event, the Medical Examinar must be inclified at 1 ☐ Yes 2 No Director Balto Randallstown Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 10 Valdivia Ct Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should ba filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ita 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Black. þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Lease Way College (1-4or 5+) Elementary/Secondary (0-12) Driver Transportation 12th grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Priscilla Loftin Lorenza Staten ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanetta Staten - Daughter 1 Sturgis Court Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/2004 Randallstown, Md permit. Page Department of Important: If any injury or once. King Memorial Park 4 Deflation 5 Other (Specify) 22. Name and Address of Facility 21. 2 gnature of Funeral Service Licersee March F/H West Magnon 4300 Wabash Avenue Balto, Md 21215 Lome 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GIRRHOSIS Physician /Medical Due to (or as a consequence of): PERBILIRUBENEMIA Examiner Sequentially list conditions, cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 2 been signad b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑No 2 this After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 🗌 Homicide within 24 hours \_\_\_\_\_To the Funeral Dir 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle PS1722 MD 2004 MARCH 3 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar LEONARD

32' Registrar's Signature

RICHARDSON M.D.

5602

BALTIMORE NATIONAL PIKE #603, BALT. MD. 21228

_			1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cer</i>	rtme tifica	nt of Hea <i>te of De</i>	ilth and N ath		giene Reg. No.	200	) 4	0719
	Physici /Medio			Smith						2. Date of De Month	Day	8 20		3. Time of Death
	Examir Funeral Director	ner	5. Social Security Number 6. Sex	Health can		ast birthday) Yrs.	B			8. Date of Bin (Month, Pa FEB 1	th N	County of E I/A 9.	Birthol	ace (State or Foreign Tand
		ž	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		10c. City	onsvil				1110 12	, 10	00   11		Dd. Inside City Limits
	ith with the Maryla 23s or 28s-f shor	Funeral Director	10e. Street and Number  1916 Tadcaster Ro		Cat	OHSVII	10f. Z	ip Code			10g. Citiz	zen of Wha	t Count	
36	rs after deatl ', or Items 2	by Funera		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:		If	/as Dece Yes, sp	edent of Hispar ecrity Cuban, M	nic Origin? (Splexican, Puerto	pecify Yes or No Rican, etc.)		I4. Race - A Black, V Specify:	Vhite, e	un Indian, No. White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or Items 23s or 28s-f show int, Ite Marklaul Ezaminat minal be notitied at	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	+)	(Give A	and of w	ual Occupation ork done durin use retired)	g most of work	king		nd of Busine	ess/Ind	ustry
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	ss 1 and 2 should be filed of Health and Mental Hyg ilam 27 is marked otha r othar traumatic event,		19a. Informant's Name/Relationship (Ty) Bette Nordbruck/F		20h D	1916	Tac	s (Street and I	Number or Rui Road	ral Route Numbe Catons	or, City or Vill	Town, State, MD	2	1228
Baltimore,	Pages nent of ant: If i		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Fungral Service Licensi		Ce		atory or matc	other place) bry Inc	. 3-8-		Ва	ation - City  1timo		
Ba	permit. Departr Imports any inji		Thomas Grego  23a. Part1. Enter the disease, or complishock, or heart failure. List only or		the death		299	Freder:	TCK KOS		timo	re, M	1	21228 Approximate Interval Between
	Physic an /Medical Examiner	Iner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	on io- i consequ	ence of):								Onset and Death Sidowy S
68760,	ficate be executed physician and s the burial-transii	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	ence of);								
30. Box	n requires that the death certif been signed by the attending should be detached for use a	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3 🗆	Ectopic p Other (s	oregnancy pecify)			2	3d. Date of Month		Y Day Year
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HOUNTER	ysician: The law is certificate has b director, page 2 st	Completed	25 Was associated to redical							24a. Was autop perfor 1 Yes	sy med? 2 No	prior death	autops to com 1? 'es 2	sy findings available pletion of cause of
T Jo	ling Physicia n. After this certi funeral directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No H	ospital: 1 Impatier 28a. Date of Injury (Month, Day		ER/Outpatient 28b. Time of		OA Other: 4	☐ Nursing Ho	h (Check only of ome 5 ☐ Resid 28d. Describe h	lence 6		pecify)	
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5	he Hospital n 24 hours ha Funaral pletely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of er: On the basis of and manner stat	examinati	vledge, death ion and/or inve	occurred	l at the time, dans, in my opinion	ate and place, n, death occurr	and due to the o	ause(s) a	and manner place, and c	as stat	ted. he cause(s)
	To t With To t Com	Σ	29b. Signature and title of certifier  Molamore	ed mo				c. License nun P1760				signed (Mo		
	Sta Registr	2 11	30. Name and address of person who con No. ee M. hammed 31. Date filed (Month, Day, Year)	mpleted cause of de	r's Signat		rint)						, 20	

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	Physici	an	Decedent's Name (First, Middle, Last     TID TITE     A BATAT					2. Date of Death Month March	_	3. Time of Death
	/Medic		JUDITH ANN  4a. Facility Name (If not institution, give	SINDT street and number)		4b. City, Town, or	Location of Deat		4c. County of [	11:00 A.M
	LXaiiii	) 	Gilchrist Center	:		Tov	vson		Balti	more
	Funeral Director		407-44-9950	7. Age (in yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 9. 1939 ]	Birthplace (State or Foreign Country) OWA
	itied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examerational Legicalities at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim  10e. Street and Number		, Town or Lo			110	ng. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 ☒ No it Country?
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020	ges 1 and 2 should be filed within 72 hours after death w tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examinational	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba t □ Yes 2\\ No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
213-0030	ithin 72 ho ne. nen "netur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wor )	rking	16b. Kind of Busin	ess/Industry
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ylanı	should be nd Mental marked o umatic eve	To Be	Carl VonVolte				Francis		Smith	
Mar	d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship (T)					ıral Route Number,		
поге,	Pages 1 an nent of Heal int: If itam 2 iry or other		Kathleen A. Sindt  20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Pi	lace of Dispo emetery, cren	WIIG GIN sition (Name of natory or other plac morial Gard	e)		20c. Location - City	or Town, State  Maryland
Dallimor	permit. Pages Department of Importent; If i any injury or once.		21. Signature of Funeral Service Licens		00	Alama and Addres	e of Facility	l Funeral Baltimore		William Control
2	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consequence.	st C	er the mode of dyin	g, such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death
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	with To t	W	29b. Signature and title of pertifier	uns Mile	ne	29c. License			d. Date signed (M M W ch	
	10		30. Name and address of person who co		23a) (Type,	Print) V-Chal	Es St.	Balts	md Zc	3,2004
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	Physici /Media	100	1. Decedent's Name (First, Middle Walter			Sim	ionsei			Date of Dea	1 5 s	Year 2004	3. Time of Death 0735 M
	Examir Funeral	er	4a. Facility Name (If not institution, Johns Hopkins B 5. Social Security Number	Lyview Mec	1 1 1	Enter ast birthday)	4b. City, Town	Balt ar If Unde	more	B. Date of Birth	1	N/A 9. Births	place (State or Foreign
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	ne Marylau 8a-f ahow billied at	Director		N/A	10c. City	, Town or Lo	Balt	imore	City				10d. Inside City Limits 1
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any njury or other traumatic event, the Medical Exam har must be notified at ODEs.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ed 1 D Yes 2 [ If Yes, Give Year or Date	s? ⊒No		Was Decedent of fYes, specify C 1 ☐ Yes 2 ☑ N			ity Yes or No- ican, etc.)	Spec	ace - Americ lack, White, cify:	
21215-0036	within 72 ho lene. Than "natur he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during mo ired)	st of working	7	16b. Kind of	:	dustry
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, Maryland	and 2 should leath and Men m 27 is marke	-	19a. Informant's Name/Relationsh Mrs. Anna Simo		e		ng Address <i>(Stre</i> Elrino	et and Numb	er or Rural I	Route Number	r, City or Tow	m, State, Zip	Code)
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any njury or othe once.	- 88	20a. Method of Disposition 1 Burial 教堂Cremation '4 Donation 5 Other (Sp		te ce	metery, crei	sition (Name of matory or other p Service	, i	Da		20c. Location	•	own, State
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	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pact Due to (or a	erial as a consequ  NC O	ence of): OSTU	ctive	pice pulm	onar	y dis	ease		3 months
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P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal at time of de	death 3	Ectopic pregnal					Date of delive	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditio	ns contributing to death	but not resu	lting in the u	nderlying cause	given in Part	1.	23e. Did to			ne cause of death?
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	Attending Physician: The I r death. ector: Atter this certificate ha ector, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	,		ER/Outpatier 28b. Time of Injury	28c. In	Other: 4 N	ursing Home 28	Check on   on 5 □ Reside d. Describe ho	ence 6 🗆 O		1)
Division of	i gite	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory, offic	ee	28	f. Location (St City or Town	reet and Num n, State)	nber or Rura	d Route Number,
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)	To To COM	2	29b. Signature and title of certifier	15the				lse number	00	3	9d. Date sign	S 2	Day, Year)
2	:11	to	30. Name and address of person v JOSHUA BOYNS 31. Date filed (Month, Day, Year)	tein mb	f death (Item 40 strar's Signati	140 E	astern	Aden	ue B	attino	re, M	0212	24
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name /First Middle Last) Month Day KOBERT THORNTON 3:250 EE 4b. City, Town, or Location of Death 5004 4a Facility Name (If not institution, give street end number) 4c. County of Deeth BALTIMORE If Under 24 Hrs. 8. MARIS IA 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) Days Hours Months 10 M 20 F 216 · 30 · 8828 Usuel Residence of Decedent Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No NIA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 F AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1211 GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRANK SHORNSON BANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIHLER DAKS MOKES FOOLE , OWINGS MILLS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST 03-09 04 DWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licenses of Familie VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. En exple disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1cains Due to (or as a consequence of) Due to (or as a consequence of) given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Peges 1 end 2 should be filed with nant of Health and Mental Hygiena.

Health tem 27 i

6 Depertment of important: if any Injury or

**Physician** 

/Medical

10a. State

**Funeral Director** 

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Completed

Be

Examiner

**Funeral** 

Director

Maryland 21215-0020

Baltimore,

Examine by Physician/Medical Completed Be Medical Certification: To s efter dea... ral Director: After un-

Hospital or Attending Physician: The law requires that the death certificata be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Part II. Ot

4 ☐ Homicide

31. Date filed (Month,

29b. Signatura and title of certifier

ted events in death) Lest		Due to (or as e consequence of):
	d	
her significant con	ditions contributing to	death but not resulting in the underlying cause

24a. Was an autopsy performed?

1 Yas

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 05/11 CC 1 Yes 2 No 28b. Time of

28a. Date of Injury (Month, Dey Year) 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 3 ☐ Suicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

212No

29a, Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer) 29c. License number

40854

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sebera 32. Registrar's, Signature

Baltimore PAUL

State Registrar

D

fillad in by

within 24 hours e
To the Funeral C
completely fillad

To the

**DHMH 16 Rev 6/95** 

			1 - For Item 23a per Dr.	State of M ,G829,03/	larylan 09/04dl	d / Depa nb <i>Cer</i>	rtment of tificate of	Health a Death	and Me	ental Hy	giene Reg. No	201	04	07200
		,	Decedent's Name (First, Middle, Last)						1	2. Date of De			ear	3. Time of Death
	Physici /Medic		John Max Tores Sr	•						Februa				17:30 P <sub>M</sub>
*	Examin		4a. Fecility Name (If not institution, give st				4b. City, Town,		of Death		40	. County of	Death	
			Anne Arundel Medica				Annapol If Under 1 Year		24 Hrs	Data of Die		nne Ai		
	Funeral		5. Social Security Number 6. Sex 1 💢	M 2□F	ge ( <i>In yr</i> s. 1 85	ast birthday) Yrs.	Months Days		Min.	3. Date of Bir (Month, Da une 11	ıy, Year)		Count	4'
h	Director		Usuaf Residence of Decedent		0.0				J	une 11	, I	710 P	lal y	land
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation						10	Od. Inside City Limits
	Man a-fat	tor	Maryland Anne Arun	de1	Mil1	[ersvi	.1e							1 ☐ Yes 2 XNo
	th the	irec	10e. Street and Number				10f. Zip Code				10g. Cit	izen of Wha	at Coun	try?
	23a	Funeral Directo	8391 Elvaton Rd.				21108				USA	=		
	tems	nue	TT. Marker Otacos	2. Was Decedent Armed Forces	?	S. 13. \	Vas Decedent of Yes, specify Cu	Hispanic Ori ban, Mexical	igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	)~	14. Race - Black, 1	America White, e	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examirar must be rediffed at	by Fi	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:			☐ Yes 2X No	Specity:	:			Specify: W	hit	e
3	hour fural	ed b	15. Decedent's Educ			16a. Deced	ent's Usual Occu	pation			16b. K	ind of Busin	ness/Ind	lustry
Ç	in 72	plet	(Specify only highest grade Elementary/Secondary (0-12)		5.\	(Give	kind of work done OO NOT use retir	e during mos	at of working	7				•
212	filed with Hygiene. other ther	Completed	12	College (1°401	3+)	Truck	Driver				Cor	ıstruc	tio	n
פ	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or Itema 23a or 28a-1 show event, the Medical Examinar much bu routified at	Be C	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (	First, Middle	, Maider	Sumame)		
<u>a</u>	should be nd Mental marked matic ev	ToE	Adolf Nicholas Tor	es				Vero	nica	Till				
<u>a</u>	01 00 00 00	1	19a. Informant's Name/Relationship (Typ	e, Print)			g Address (Stree				2500			Code)
≥,	of Heelth item 27		Joann Cavey	Daught			Elvaton sition (Name of	Rd. M		sville		2110 ocation - Cit		um Ctata
Baltimore, Maryland 21215-0036	- T = 2		20a. Method of Disposition 14 Burial 2 ☐ Creenation 3 ☐ Re	moval from State	, C	emetery, crer	natory or other pl		M	ar 2			-	
Ē	t. Pa tmen tant:		*4 Denation 5 Other (Specify)  21. Signature (Fungral Service License		GIE		n Memori			007		Burn	ie,	MD
Bai	permit. Pages Department of Important: If if any Injury or once.		21. Signature of Funeral Service Licenses		1120	S	Name and Add					3775	017	241
	SEC. 125-25		2 a. P. rt1. Enter the times ie, or complic			n. Do not ent	Second or the mode of dy					e, MD	- 210	Approximate
			In mediate Cause (Final	e cause on each	line.		0		64					Interval Between Onset and Death
	Physician /Medical		displase or condition resulting in death)	Due to (or a	-	uence of):	200 1 001	eume	3NC				+	
	Examiner		NON-CHARGO BILL AND CONTRACTOR OF THE CONTRACTOR	Chron		18011	atin P	neumoni	a					
		Jer	if any, leading to immediate cause. Enter Underlying	Due to (or a:	s a consequ	uence of):								
	cuted	Examiner	Cause (Disease or injury that initiated events c.	Park	· IN Se	m 5 C	L see-s	e						
O,	e exercian ar	EX	resulting in death) Last	Due to (or a	s a consequ	uence of):								
8760	cate be executed physician and the burial-transit	dlcai	d.				· · · · · · · · · · · · · · · · · · ·						-	
9	leath certifica attending pt ifor use as t	Мес	IF FEMALE:	la Musa sutaam	1									
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcom	2 Fetal	death 3	Ectopic pregnan	су				23d. Date o Month		ry Day Year
<u> </u>	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of di	eatn 5∟	Other (specify)				1			
۵.	The law requires thet the de Ite has been signed by the a bage 2 should be detached t	h h	Part II. Other significant conditions cont	tributing to death	but not resi	ulting in the u	nderlying cause g	iven in Part I	l.	23e. Did t	obacco	use contribu	ite to th	e cause of death?
ds,	uires sign Id be	d by								10	Yes 2	□No 3[	_ Proba	ably 4 Bonknown
Vital Record	w requir been si should	Completed					11-17			24a. Was	an	24b. Wei	re autog	esy findings available
Re	The lay	mc									rmed?_	dea	th?	osy findings available inpletion of cause of
ē		a	25. Was case referred to medical					26 Place	e of Death	1 Yes	211 No		Yes	2L No
>	ysicien: us certifica director, p	0 8	examiner?	ospital: 1 Inpat	ient 2	ER/Outpatien	t 3 DOA	thor		e 5 🗆 Resi		6 Other	Specify	)
Division of	÷ = =	n: T	27. Manner Death	28a. Date of Inj	ury	28b. Time of	28c. lnj	ury at	28	d. Describe	how in <del>j</del> u	ry occurred		
<u>o</u>	ttending F death. ctor: After t the funer.	atio	1 Accident 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-, ,	,,		Yes 2	No					
<u>X</u>	or Attendation of Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir building, 6	njury - At ho	ome, farm, str	et, factory, office	•	28	Sf. Location (. City or To			or Rural	Route Number,
Ω	urs after rel Dire													
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin		of examina									
	thin 2 the the mplel	Med	29b. Signature and title of certifier	and manner s	natou.		29c. Licer	nse number			29d. Da	te signed (A	Month, D	Day, Year)
)	F 3 F 8		1 115				700	5582	97		21	2010	34	
			30. Name and address of person who cor	inpleted cause of	death (Item	23a) (Type.		^			- t	- (		Λ,
	0		HOWARD Your			Anne	Avand	el 1	redo	el Ca	2-4		An	repetis
	Sta	te	31. Date filed (Month, Day, Year)	A 32. Regis	trar's Şigna	ture	A					,		
	Regist	ar	MAR 0 9 2004			" - Cucho								

			1 - For Amend Item 7 p. Registrar  1. Decedent's Name (First, Middle, La	<del></del>	Се	rtificate of	Death	2. Date of De			/20 of Death
	Physic /Medi		Hannah	М.		Tille	rv	Month March	Day	Year	49 AM
	Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town,	or Location of Dea	th	4c. County o		77
			Sinai Hospital of	Baltimore		Baltimo					
	Funeral Director		5. Social Security Number 6. S  243-46-6073  Usual Residence of Decedent	Sex 7. Age (III	9 90 Yrs.	If Under 1 Year   Months   Days			y, Year)	9. Birthplace (State Country)  NC	a or Foreign
	yland how		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside	City Limits
	Ba-fs	ctol	MD NA		Baltimo	re				1 <b>2</b> Ye	es 2□No
	with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?	
	ns 23	erai	3000 Towanda A	12. Was Decedent Eve	r in U.S. 13.		.215 Hispanic Origin? (5	Specify Yes or No	U.S	• A •	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, Ite Modeal Examinet must be motified at	by Funeral Director	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes ② Volume 1f Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No		to Rican, etc.)	Specify:	, White, etc.  Black	
2-0	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu kind of work done	pation during most of wo	orkina	16b. Kind of Bus	iness/Industry	
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	nd)		Dogovo	معمدات المم	
2 2	filed Hygid other ent.	Be Co	10th grade 17. Father's Name (First, Middle, Last	na na		Nurse	18. Mother's Na.	me (First, Middle,	Maiden Surname	od State	e nos
<u>la</u> n	Mental arked o	To B	Ernest Tillery					Tiller			
Maryland	2 60 00 00		19a. Informant's Name/Relationship (	Турө, Print)	19b. Maili	ng Address (Street	and Number or Ri	ural Route Numbe	r, City or Town, S	tate, Zip Code) 2	1061
	of Health item 27 other tr		Ray Ownes-Cous:		406_	Hideawa		Apt J44	13, Gle	n Burni	
altimore,	Pages hent of Hunt: If ite		20a. Method of Disposition  XXBurial 2 Cremation 3	Removal from State		matory or other pla	· 1	Date	20c. Location - C	•	
	C 40 3		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice)	1999		Memori  Name and Addre		3/11/0	04 Arbu	tus, Md	
Ba	permit. Depart Import any inj		R. B.	Test and	, M. M.	358hw£6	H West	. Balti	more M	d 2121	5
	100	9	23a. Pan1. Enter the disease, or com shock, or heart failure. List only	nations that caused the	death. To not en	er the mode of dying	ng, such as cardia	c or respiratory ar	rest,	Approxima	ate
	Physician		Immediate Cause (Final disease or condition	a. B ceil (						Onset and	d Death
	/Medical Examiner		resulting in death)	Due to (or as a ce		746				3 mon	Ths
Н	LAGITITIE	er	Sequentially list conditions.	b							
	uted I	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	insequence or):						
a a	execting and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
3760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	icai		. d.							
õ	artifica ing ph e as th	Med	IF FEMALE:								
ROX	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	1		23d. Date of	,	Year
o.	the de y the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify) _			Wickti	Day	real
1	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death but no	at resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribi	ute to the cause of	death?
ecords,	quires an sign	ed b	Atrial fibrillation	ח				1 □ Y	es 2□No 3	Probably 4 🖔	Unknown
000	law re as bed 2 sho	ompleted	Hypertension					24a. Was a	ın 24b. We	re autopsy findings	available
r		Сош	Diabetes Mellit	45				autops perfori 1 Yes	med?   dea	or to completion of the the the the the the the the the the	cause of
VItal	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	11. 2.1				ath (Check only on			
10	Physi this c	.T	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Impatient	2 ER/Outpatien	The second secon	- Indising in		ence 6 Other	(Specify)	
	ding th. After fune	tlon;	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injun Wor M 1	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred		
DIVISION	Atten r dea sctor	ertificati	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, str			28f. Location (St	reet and Number	or Rural Route Nur	nber.
5	s afte	Cert	4 Homicide	building, etc. (S	pecify)			City or Town	n, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 125 Certifying Ph	ysician: To the best of my liner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manna ate and place, and	er as stated. I due to the cause(	s)
	To the Tro the Comp	ž	29b. Signature and title of certifier	- Nan		29c. Licens	e number	5	9d. Date signed (//	Month, Day, Year)	
	, )		Viry	74(1)		KE	5-00	0	raarch	05,200	4
	10		30. Name and address of person who kittane Vishnup	mp completed cause of death iya 2461 Me. Registrar's S	(Item 23a) (Type, SF BELVE C	Print) leve Aven	ice Bal	timore	Maryla	nd 2121	5
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 200	A. Registrar's S	Signature / 19	(E)			0		

Patient known as Hannah

04-1	1611		1- For Unpend Item Registrar	State of Marylai #23a,27,28a-f	nd/De ہے <b>per</b>	partmen ne C830 ertificat	t of He e 6/92	ealth and N Oa <sub>th</sub> tas	lental Hy	ygiene 2	004	07202
	Physic	an	Decedent's Name (First, Middle, La	ast)	<u>_</u>			- Cuin	2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, gir	Jarod ve street and number)			ich Town.ort	ocation of Death	March	03	2004 hty of Death	5:50 P <sup>M</sup>
	CXamiii	ier	1545 Harford Squa		ourt		gewoo				arford	ı
28	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. 12 M 2 F 4		ay) If Under	1 Year	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D		9. Birthp	olece (State or Foreign ortry) cvland
L.	P.		Usual Residence of Decedent									7
	how	_	10a. State 10b. County	10c. C	ity, Town or	Location					1	10d. Inside City Limits
	Ba-1	cto	Maryland N/A	<i>I</i>		Ва	ltim	ore City				ti⊠iYes 2 🗓 No
	or 2	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen o		*
	ath v 23e		1203 Horners Lar					205		United		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f ehow ont, the Madical Examinac must be motified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year of Dates:	J.S. 1	<ol> <li>Was Deceded of Yes, special Yes</li> <li>Yes</li> </ol>		panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	o- 14. Ra BI Spec	ace - Americ lack, White, eify:	
ş	thon sture	ed	15. Decedent's E		16a. De	cedent's Usua	I Occupat	ion		16b. Kind of	Business/Inc	
Baltimore, Maryland 21215-0036	d within 72 piene. r than ne	Completed	(Specify only highest gr Elementary/Secondary (0-12) N/A	ade completed) College (1-4or 5+)	(Gi	ive kind of wo s. DO NOT us Depende	rk done du se retired)	ring most of work	ing	N/A		Justiy
ਰੂ	a filed I Hyg othe	BeC	17. Father's Name (First, Middle, Las	1)				8. Mother's Name	e (First, Middle			
<u>a</u>	should be find Mental H marked of	ToE	John Ulrich, Sr.	•				Akri	sta Raj	ines		
ary	shot sand N	-	19a. Informant's Name/Relationship	(Type, Print)				d Number or Rura	al Route Numb	ber, City or Town	n, State, Zip	Code)
Σ	and 2 valth a valth a vartrau		Mr. John Ulrich	/ Father	12	203 Hor	ners	Lane	Baltimo	ore, Mar	ryland	21205
ore	of He fiterr		20a. Method of Disposition  p∑ Burial 2 ☐ Cremation 3 [		Place of Dis	sposition (Nan	ne of ther place)		Date	20c. Location	- City or To	wn, State
Ĕ	Peg nent ant: h		`4 □Donation 5 □ Other (Speci	fy) Ho	olly F	Hill Me	m. G	dns. 3/8	/2004	Middl	e Riv	er, MD
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if I tem 27 is marked other than any injury or other traumatic event, the Magnes.		21. Signature of Funeral Service Lice	nsee				of Facility uneral Ho ve. Dune				222
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the deal	th. Do not e	enter the mod	e of dying,	such as cardiac	or respiratory a	arrest,	21	Approximate Interval Between
المان	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to minimediate cause. Enter Underlying Cause (Disease or injury)	a. Smoke Inhal  Due to (or as a consect  b. Cue to (or as a consect	quence of):	And T	herma	ıl Injuri	les			Onset and Death
68760,	iicate be executed physicien and s the burial-transil	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consec	quence of):							
P.O. Box (	death certii e attending ed for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1☐Live birth 2☐Fete 4☐Pregnant at time of c	al death 3	3 □Ectopic pr 5 □ Other (sp					ate of delive	ry Day Year
rds, F	- "	þ	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying ca	tuse given	in Part I.				e cause of death?
al Reco		Completed							24a. Was auto perfo	psy ormed?	Were autop prior to con death? 1 2 Yes	osy findings available npletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: Th within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director. pag	on: To Be	25. Was case referred to medical examiner?  11 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1  Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpati		Other	26. Place of Death  4 □ Nursing Hor  t	me 5∐Resi			at scene
<u></u>	endii eath. or: A he fu	atle	2X Accident investigatio	n 3/3/2004	5:25	P M	1 □ Ye		ictim (	Of House	e Fire	<u>*</u>
Divis	tal or Att	Certification:	3 Suicide 6 Could not be determined		ome, farm, : fy)	street, factory	office	E	281. Location ( City or To	Street and Number 152	45°F°C	Route Number, OUT L
	the Hosp in 24 hou the Funer	Redical	one) 2X Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, de ation and/or	investigation,	in my opin	ion, death occurre	and due to the ed at the time,	date and place,	and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	•		290	License r		_	29d. Date signe		**
			1 Unesc					O.C.M.	E.	March	04, 20	)04
				RUBIO, MD	1	l 11 Pen		reet, Bal	ltimore	, Maryl	and 21	1201
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9	32. Registrar's Signa	Ature //	Spark						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Dorothy 7:55A M Marys Vonbarby March 6,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F Director 261-44-7417 95 March 28, 1908 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner round be notified at MD Frederick Frederick **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 5820 Genesis Lane 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 \ Widowed 4 Divorced Year or Dates natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Augustus Riggs, III Amalia de Murguiondo and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Legartment of Health ar, importent: if item 27 is n any injury or other in once. Mrs. M. Nomita Brady (Daughter) 5308 Burling Terrace, Bethesda, MD 20814 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Oak Grove Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2004 Glenwood, MD 21. Signature of Funeral Service Licensee HATCHIO FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the list of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed the burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No patient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Director: After Division 5 Pending investigation Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide ö within 24 hours a To the Funerel C the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah 65-C. Thomas ohnson 3 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 2004 Registrar

			1 - For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment <i>rtificate</i>	of Heal	th and Math		giene 20	04	072	204
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t,	Funeral Director			744 00 =	80 Yrs.			urs Min.	8. Date of Birti (Month, De) JUNE 2	4,1923	9. Birthpl Count	ece (Stete or ry)  V	r Foreign 1D
	with the Maryland a or 28a-f show be notified at	Director	MD BALTI  10e. Street and Number		PIKE	SVILLE						0d. Inside Cit	•
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Mudical Exprinter must be notified at	Funeral Dir	4512 DRESDEN ROAD	12. Was Decedent Ever in t Armed Forces?		10f. Zip Co Was Deceder If Yes, specify	2:	1208 c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race Black		ın Indian,	
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d 2121	be filed within 72 hatal Hygiene. d other than "natuevent, the Medical	Completed	Elementary/Secondary (0-12)  4  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	ACCOU	DO NOT use	retired)			ACCOUNT		_	
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Baltimore,	permit. Pages Department of a Important: If It any injury or o ance.		1 ABurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	A[	DATH YE	-	CEM.	3/7/2		BALTIN ON & BRO			
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Division of Vital Record	Attending Physician: The relation of the state octor: After this certificate by the funeral director, pages	ation: To Be	25. Was case referred to medical examiner?  1   Yes   2   No	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other	Nursing Hon		e) ince 6 Other w injury occurred	(Specity)		
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	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Aedical	one)	sician: To the best of my knot her: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in	my opinion,	death occurre	nd due to the da id at the time, da	itsa(s) and mannate and place, and	or as stat I due to th	ad ne cause(s)	
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	Sto	to.	30. Name and address of person who co TASNEEM AK 31. Date filed (Month, Day, Year)	mpleted cause of death (Iter 14477/ 722 32. Registrar's Signa	O PA	ek t	teran	473 /	FVE, E	ALTO 1	11) 3	21208	7
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,		30. Name and address of person who o	ompleted cause of death (Item	23а) (Туре	. Print)	01. 1	1.	600 N.	Wol	fest.	1
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State Registra	-	MAR 0 9 200	and manner stated.  To MD  ompleted cause of death (Item  Hopkins Hespital  32 Registrar's Signat	1	246						

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examined: .ust be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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edical C		Examiner: O	To the best of my length the basis of examined manner stated.								

State Registrar

MAR 0 9 2004

LI.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

111 Penn Street, Baltimore, Maryland 21201

LING 31. Date filed (Month, Day, Year)

			1 - For Amend Item 5 pe Registrar		ryland / l 12/04dhb	Depa <i>Cer</i>	irtment of H tificate of L	ealth and M Death	R	eg. No.	004	07207
4	Physici	an	1. Decedent's Name (First, Middle, La						<ol><li>Date of Deat Month</li></ol>	h Day	Year	3. Time of Death
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	h with	O JE	1760 Baldwin Dr	ive			21108			U.S	. A .	
	deati	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spendar)	ecify Yes or No-	14. Ra	ce - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exameter must be mollified at 2008.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		□Yes 2X No	Specify:		Specia		ite
5-0	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	(Give	lent's Usual Occupa kind of work done d	urina most of worki		16b. Kind of E		dustry ges County
121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5-			OO NOT use retired)					•
<b>d</b> 2	Hygie Hygie Sther		12 17. Father's Name (First, Middle, Last	)		ecr	etary	18. Mother's Name	(First, Middle, N	Schoo Maiden Sumai		tem
Maryland	Mental Mental Med o	To Be	John E.		Boswe1	.1		Mary	J.	De	utsch	
ary	should be and be		19a. Informant's Name/Relationship (				g Address (Street a		I Route Number	City or Town	, State, Zip	Code)
	s 1 and 2 if Health a Item 27 is other trau		Terrence Howard/	Daughter	14,900	100	olly Road		ater, Ma	ryland	210	37
altimore,	Jes 1 of He If Iter		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. Place o	t Dispo	sition (Name of natory or other place of Field	) !		20c. Location	-	
ţ	tment tant:		* 4 ☐Donation 5 ☐ Other (Special	fy)	Cathol	ic	Cemeterv	1 3/3/2				e, Maryland
Bal	Departiment Depart		21. Signature of Funeral Service Lice	with			Name and Address					
		þ.	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ente	er the mode of dying	, such as cardiac c	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	PSIS							Oriset and Death
	/Medical Examiner		Tosuming in dealing	Due to (or as a	consequence	of):						
	100 mm	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence	of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter incarrying Cause (Disease or injury that initiated events									
oʻ	an an rial-tr		resulting in death) Last	Due to (or as a	a consequence	of):					30	
68760,	ficate be executed physician and s the burial-transit	edical		_ d								
_	·= 07 rd		IF FEMALE:									111111111111111111111111111111111111111
P.O. Box	that the death certii ed by the attending detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				te of delive onth	ny Day Year
	es De	þ	Part II. Other significant conditions of	contributing to death bu	it not resulting i	n the ur	derlying cause give	n in Part I.				e cause of death?
Records,	law as b	Completed							24a. Was ar autops perform 1 Yes 2	ned?	death?	osy findings available npletion of cause of
Vital	ysicien: The is certificate hi director, page	Bec	25. Was case referred to medical examiner?					26. Place of Death				
of V	Physicien: this certific ral director,	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier				4   Nursing nor	me 5 Reside			9
	ing P	.io	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Yeer) 28b.	Time of Injury	28c. Injury Work		28d. Describe ho	w injury occur	red	
isio	Attanding r death.	Icat	2 Accident investigatio 3 Suicide 6 Could not b	OB Place of Injur	ar - At home for	rem otro		es 2 No	29f Logation (Ct	mad and Mumi	has as Owen	I Cauta Number
Division	for A after Direc	Certification;	4 Homicide determined	28e. Place of Inju building, etc	(Specify)	iim, sire	et, ractory, office	1	28f. Location (Str City or Town	, State)	oer or murai	Aoste Number,
	To the Hospitel or Attanding within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	hysicien: To the best of miner: On the basis of and manner state	examination an	e, death	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as sta	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	and mainter state			29c. License	number	29	d. Date signe	d (Month, E	Day, Year)
	P S P Ö		1/1 7	1/ 1	10		0	5518	7	3/4	104	
	6,		30. Name and address of person why	completed cause of de	eath (Item 23a)	(Туре, І	Print) N	1	1	10	1	
	`		Hinee		A	nn	- Arand	lel M	120/100	-1 (	K-	L
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 200	100	r's Signature	ha	the .					

		1 For State Registrar  1. Decedent's Name (First, Middle, Las.	State of Maryla	and / Depa Cea	artment of H	lealth and Death		Reg. No.	11111.	07208
/Me	sician edical miner		Paige W street and number)	ensha	4b. City, Town, or Baltimo		Month 3	Dey (	200 y unty of Death	3. Time of Death
Funer Direct		5. Social Security Number  227-36-1569  Usuet Residence of Decedent	x □ M 2 F 7. Age (In yr	s. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		h v. Year)		tace (State or Foreign try) Va
Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland lift and Mental Hygiene. 27 is marked other than "netural", or Items 23e or 28s-1 show reaumatic event, the Musical Exerciting man the routing at	Completed by Funeral Director	3 🕅 Widowed 4 □ Divorced  15. Decedent's Ed. (Specify only highest grad  Elementary/Secondary (0-12) 12th grade	A I  Venue  12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ② No If Yes, Give Year or Dates:	16a. Dece (Give life.	10f. Zip Code 2121	ispanic Origin? In, Mexican, Pu Specify: ation furing most of w  ide	(Specify Yes or No- erto Rican, etc.)	U S	of What Counds A  Race - America Black, White, e  pecify: B  of Business/Ind  ood Sta	an Indian, etc. lack
Baltimore, Maryland permit. Pages 1 and 2 should be fit Department of Health and Mental H important: If item 27 is marked oft any injury or other traumatic even	e	17. Father's Name (First, Middle, Last) James A. Giles  19a. Informant's Name/Relationship (7) Phyllis E. Brown  20a. Method of Disposition Wall Burial 2 Cremation 3 Figure 1 Constitution 1 Constitutio	- Daughter Removal from State	1370 Place of Dispo cemetery, crem Md Nati	Pentwood sition (Name of natory or other place onal Mem	Este	ame (First, Middle, lle Smith Gural Route Number 3 alto, Md Dete 12-2004 arch F/H Wabash Ave	r, City or To 21239 20c. Locatio Laure1 West	wn, State, Zip  on - City or Tov	wn, State
by Scien and by Scien and the burial-transit	al er	23a. Part 1. Enter the disease, or compostock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 and	a.  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	equence of):	er the mode of dying	g, such as card	ac or respiratory an	est,	3	Approximate Interval Between Onset and Death
hat the death certify but the attending.	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions co.	23c. If yes, outcome of preg  1 Live birth 2 Fe  4 Pregnant at time of 9 Unknown	tal death 3 (death 5 (	Ectopic pregnancy Other (specify)	o in Part I	22a Did to			Day Year
The law requires tha cate has been signed to page 2 should be detailed.	pleted b	Hypertension,	Hypertip		_			es 2 No	3 ☐ Proba	ably 4 Unknown  asy findings available apletion of cause of
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To Be	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	fospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day Yeer)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing	eath (Check only or Home 5 Residence 28d. Describe home	ence 6 🗆 (		1
Hospital or Attending to hours after death. Funeral Director: Afte	edical Certification:	(Check only 2 Medical Exami	28e. Place of Injury - At building, etc. (Specialization) as the best of my kner: On the basis of examin	cify)  nowledge, death	occurred at the tim	e, date and placinion, death or	28f. Location (Si City or Town	n, State)	manner as sta	ited
To the P within 24 To the F complete		29b. Signature and title of certifier  30. Name and address of person who co	elle	\u00e4n	29c. License				ned (Month, D	
	State istrar	31. Date filed (Month, Day, Year) MAR 0 9 2004		0 100 b	1	es 5	= #illo	, Bo	ILIMOYE	-, ma 2120

			1 - For State Registrar	State of Mary	land / Depa		lealth and l	Mental Hyg	-	07209
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La:     Sarah J. Wi      Aa. Facility Name (If not institution, give     Joseph Richey Ho	11iams		4b. City, Town, o Baltimo	r Location of Death	2. Date of Death Month March 8	Day Year	3. Time of Death 7:28 A M
ay .	Funeral Director		5. Social Security Number 6. S	-	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 30,	Year) 9. Bir	thplace (State or Foreign puntry) nnsylvania
	he Maryland 28a-f ahow cuffed at	ector	Maryland N/A		c. City, Town or Lo Baltimore			-1		10d. Inside City Limits 1 Yes 2 No
	th with t	al Dir	10e. Street and Number 5905 Berkeley Ave	nue		10f. Zip Code 21209			0g. Citizen of What Co USA	ountry?
036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-f show the Modical Exeminer must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Never Married 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	f within 72 ho iene. r than *naturi ithe Madical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired aker	during most of wor.	king	Own Home	Industry
Maryland ?	should be filed ind Mental Hygir i marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  John Stewart				Jacquel	ne (First, Middle, M ina Moor	e	
	s 1 and 2 sho if Health and Item 27 is my other traum		Barbara G. Pieti 20a. Method of Disposition	la/Niece		Berkeley	Avenue	Baltimo	City or Town, State, 2 re, MD 21 0c. Location - City or	209
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other freumatic event, Its Madical Examinator must be notified at once.	E	1 Burial 2X Cremation 3 \( \) 4 Donation 5 Other (Specify  21. Signature of un-al Service	riemovar from State	Metro Cr	ematory 1	Inc. 3-9	of MD, In	Baltimore,	
	Physician /Medical Examiner	5 - CO - CO - CO - CO - CO - CO - CO - C	23a. Part1. Enter the disease, or companies, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	a Static	or the mode of dyin		or respiratory arre	imore, MD	Approximate Interval Between onset and Death
760,	te be executed ysicien and e burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor  Due to (or as a cor						
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1000	- C.F.C	23d. Date of deli	ivery Day Year
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions or	entributing to death but not	t resulting in the un	derlying cause give	en in Part I.		acco use contribute to	the cause of death?
al Records,	icien: The law re certificate has be rector, page 2 sho	Completed						24a. Was an autopsy performe	ed2 prior to death?	topsy findings available completion of cause of
f Vital	Physicien: this certifical al director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1  Inpatient	2 ER/Outpatient	3□ DOA Othe	ar	th <i>(Check only one)</i> ome 5 ☐ Residen	ce 6 🗷 Other (Spec	IN hespie
Division of	ding h. After funer	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea				28d. Describe how	injury occurred	
Div	afte Dir		4 Homicide determined  29a. Certifier 1 Certifying Phy	28e. Place of Injury building, etc. (Sc	knowledge, death	occurred at the tim	e, date and place,	City or Town,	ise(s) and manner as	stated
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	one)	iner: On the basis of exar and manner stated.	mination and/or invi	estigation, in my op	minion, death occur	red at the time, dat	e and place, and due	to the cause(s)
1	To Too	4	29b. Signature and fittle of certifier	fluri	, mo	29c. License	1056211 1 mare, 1		1. Date signed (Month)	n, Dey, Year)
	Sta	te	30. Name and afforess of person who of 300 ( 31. Date filed (Month, Day, Year)	ompleted cause of death  ANDV  32. Registrar's S	er St.	Sal	pmore, 1	on 215	275 JoH	N F. IRWAN
	Registr		MAR O	9 200			3			FF1 /

safah Williams 318164 7:28 am

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** M-Wilkens Elsie /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death 4c. County of Deeth **Examiner** 115 Fifth Ave Lansdowne Baltimore If Under 1 Year | If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth (Month, Dey, Yea 4/22/1935 Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1□M 2∰F 213-30-5866 68 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No MD Baltimore Director Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code natural, or Items 23a or 115 Fifth Ave 21227 deeth Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Printing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William P. Morris Ethel Irene Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Wilkens / husband 115 Fifth Ave Lansdowne, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery March 6,2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Funeral e vice Licensee 2719 Hammonds Ferry Rd Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Lung **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, Directo for as a consequence off Examiner It any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 1 1 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies D18587 cause of death (Item 23a) (Type, Print) Name and address of person BACTIMORE GORMLE LATON 00 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month MARCH 2004 Physician 3:26 PM GLORIA OSTENDORF WEYRICH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Baltimore Saint Joseph Medical Tawson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 2, 1937 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Maryland 214-36-9949 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-1 shov other traumatic event, it a Micdical Examinar must be inclined at 1 ☐ Yes 2 No Timonium Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 2215 Spring Lake Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status illed within 72 hours after 1 Never Married 2 Married
3 Widowed 4 Divorced Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 years College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve Pages 1 and 2 should be Ostendorf Harriet Virginia King John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Spring Lake Drive Timonium, Maryland 21093 (husband) Carroll Weyrich altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Green Mount Crematory 3-9-04 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Genzi Terrans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA OF THE LUNG Pnysician YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed physicien at s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? ģ 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 385 autopsy page certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 SIL 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After t or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical oletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 9 2004

LAH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D17695

March 8, 2004

			1 - For State Registrar	State of Maryl	•		nt of He			Reg. N	e 200	+ 0721
	Physici /Medic		1. Decedent's Name (First, Middle, Las Edward	Wei	ner				Marc	h 8, 2	ay Year 2004	3. Time of Death 2:40 A M
	Examin Funeral	er	4a. Facility Name (If not institution, give Milford Manor  5. Social Security Number 6. Social Security Number	Nursing Ho	rs. last birthday	H	Pikes erlYear	Ville If Under 24 Hrs. Hours Min.		of Birth		imore thplace (State or Foreign
poel	Director		217-12-9884 1  Usuel Residence of Decedent  10a. State 10b. County	21	Yrs.  City, Town or L	ocation			APR	15, 1	921   Ma	aryland  10d. Inside City Limits
the Man	r 28a-f eh inotified	irector	Maryland Baltimo:	re Ba	altimore		ip Code		-	10g. C	citizen of What C	1 □ Yes 2 ☒ No ountry?
iw dead	ems 23a o	Funeral Director	8617 Windsor Mil	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Dec	244 edent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes o Rican, et	or No-	A 14. Race - Am Black, Wh	
17215-0036	perint. Tages I and a should be they make a should be should also perint in the should be should	þ	1 Never Married 2 Married 3 Twidowed 4 Divorced	1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates:		1 🗆 Yes	•	Specify:			Specify: Kind of Business	White
21215-0036	Hygiene.	Completed	15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of v DO NOT	vork done di use retired)	uring most of wor	king			e Repair
	Mental Hygi Marked other	To Be C	17. Father's Name (First, Middle, Last) Henry Weiner					18. Mother's Nar		Middle, Maide		
2 7	Health and Mealth and Mealth and Its man	_	19a. Informant's Name/Relationship (1) Louis Weiner/Son	Гуре, Print)				nd Number or Ru k Road	ral Route I	Number, City	or Town, State,	
Baltimore,	Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	b. Place of Disp cemetery, cre Metro C	remat	ory I	nc. 3-8			Location - City o	
Bait	Department Important: Important: I eny injury o		21. Signature of Edward A. Gr	egorchik	2	2. Name Crema 299 I	and Address ation reder	s of Facility Society ick Road	of MI	D, Inc altimo	re, MD	21228
760,	hysician hysician and hysician and hysician and hysician and hysician and hysician sit and	icai Examiner	23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conduct.  Due to (or as a conduct.  Due to (or as a conduct.  Due to (or as a conduct.)	sequence of):	»,e	© p ∈ 1		or respiral	tory arrest,		Approximate Interval Between Onset and Death
P.O. BOX 68	d for u	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	etal death 3		pregnancy specify)				23d. Date of de Month	livery Day Year
ras, r	whether that the should be detached	ed by Pr	Part II. Other significant conditions of	ontributing to death but not	•				23e.			o the cause of death?
Rec	ate has b	Complet	Die Autia M	ellatos					24a.	Was an autopsy performed?	prior to	utopsy findings available completion of cause of s 2 No
la la	this certificate al director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea				
	this o	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		28c. Injury	r: 4 Nursing H			6 Other (Spending)	ecify)
SION	Attending r death. actor: After by the funer	Certification;	1 V Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	(Month, Day Yea	r) Injury	М	Work 1 🗆 Y	? ′es 2 □No				ural Route Number,
DIV	to the hospital of Atlenting within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	il Certii	4 Homicide determined  29a. Certifier 1 Certifying Ph	building, etc. (Sp.	ecify)			e date and place	City	or Town, Sta	ite)	
	thin 24 hc thin 24 hc the Fun mpletely	Medical	(Check only 2 Medical Exer	niner: On the basis of exar and manner stated.	nination and/or	nvestigatii	on, in my op	inion, death occu	rred at the	time, date a	nd place, and du  Date signed (Mon	e to the cause(s)
,	- 3 H 8						0.0	0				
P.	\		30 Name and address of person who	completed cause of death	Item 23a) (Type	. Print)		-9083			arch 8,	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	25	(0)	2 10 C	2011	Ra	00	2/133

Amend Item 8 per 11,6829,03/11/04dhb

			1 - For State Amend Items 27,2	State of Ma 8a-f per ME,	ryland / [ G829,03/	Departmen 1907 tillbate	t of Health a e <i>of Death</i>	nd Mental Hy	giene 2 0 0 4	07213	
	Physic		1. Decedent's Name (First, Middle, Last)  ARON ALEKSANIDIRO VICH  2. De						Day Yeer	3. Time of Death	
R. W.	/Med Exami Funeral Director	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4d. County o								
	and **	17.	Usuel Residence of Decedent						10d. Inside City Limits		
	Marylan -t ahow fled st	tot/	MD N/A BALTIMORE						1 TYYes		
	or 28a-t	(3)	10e. Street and Number	<u></u>		10f. Zip			10g. Citizen of What C	ountry?	
	er death wi Itema 23a nermust b	屋	3601 FORDS LANE				2121			U.S.A.	
920	la o	by Funeral Director	11. Marital Status  1 □ Never Married 2 🕅 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		13. Was Deced		in? (Specify Yes or No Puerto Rican, etc.)	Black, Whi		
5-0036	72 hours "naturel",	100	15. Decedent's Ec	lucation de completed)	16a.	Decedent's Usua (Give kind of wor	rk done durina most (	of workina	16b. Kind of Business		
2121	il Hygiene. other than "r	19 Be-Company	Elementary/Secondary (0-12)	College (1-4or 5-	s	ALESMAN	e retired)	•	CLOTHING		
land	should be filed ad Mental Hygis marked other imatic avent, II		17. Father's Name (First, Middle, Last) YITZCHAK			ALEKSANDROVICH RAIS		s Name <i>(First, Middle,</i> ISA	· ·	OIZMAN	
Maryl	nd 2 should sith and Men 27 la marke r traumatic	3	19a. Informant's Name/Relationship ( SOFIA ALEKSANDRO	•	1				er, City or Town, State,		
	es 1 and 20 Health fitem 27 r other tr	1100	20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of	Disposition (Nan y, crematory or of	ne of	Date DALI	20c. Location - City or		
Baltimore	Pag nent ent: b	6.0	1 🎗 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			FILOH CE	METERY 2	2/29/2004	WOODLAN		
Ball	permit. Pag Department Importent: bany injury o	113	21. Signature of Funeral Service bicer	,see					SON & BROS PIKESVILLE		
	Dt.	00	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. Vast only one cause on each line.  Approximate Interval Between Onset and Death disease or condition								
	Physician /Medical	3	disease or condition resulting in death)	a. Due to (or as a			Class	Mechael	6/		
N .	Examiner	43	Sacurities y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence	-					
	ocuted nd transit	aryin,	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
68760,	icate be executed physician and s the burial-transit	dica/Examingt	resulting in death) Last	Due to (or as a	consequence	of):					
•	tificate ig phy: as the		9	. d.							
O. Box	ath cer attendin for use	Physician/M	PFEMALE:  23b. Was decedent pregnant in the past 12 months?  1						23d. Date of de Month	23d. Date of delivery Month Day Year	
ds, P.O	uires that the de signed by the a d be detached i	ò	Part II. Other significant conditions continuous to dealin but not resoluting in the underlying cause given in Part I.								
Records,	e law requir has been si je 2 should	pjeted	Fibrillation;	RIGHT	T HAP	TOLAR		24a. Was	an 24b. Were at	utopsy findings available completion of cause of	
E R	cate ha	Con	1000	@ TA11	414	Bens		perfo	rmed? death?	2 No	
Vital	Physician: this certificated director.	100	25. Was case referred to medical examiner?	Hospital:	2 D E B/O		0.1	of Death (Check only o			
ō	After fune	图	27. Manner of Death  S ☐ Pending	Manner of Death   28a. Date of Injury   28b. Time of Injury   28			28d. Describe I	dome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  Subject fell			
Division		Certificati	3 Suicide 6 Could not b				City or Tov	281. Location (Street and Number or Rural Route Number, City or Town, State) 3601 Fords Lane, #418 Balto., MD			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of and manner stat	examination an	, death occurred ad/or investigation,	at the time, date and in my opinion, death	place, and due to the	cause(s) and manner as date and place, and due	s stated.	
	To the within To the comple	Me	29b. Signature and title of certifier	16	. ^	290	. License number		29d. Date signed (Mont		
			1	my.	hep)		0 1950-	2	Februiny	27 2004	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ONIANDO C. CANANAN, M.)  RANDOUS CON ANAN, M.)  RANDOUS CON ANAN, M.)								
	St Regis	ate trar	31. Date liled (Month, Day, Year)  MAR 1 0 2004	32. Registra	r's Signature	colle					

		•	For State Registrar	State of	Maryland	•	irtment of H tificate of I			iene ZUU4 og. No.	0/214
Physic /Medi Examii			Decedent's Neme (First, Middle     SALLIE	and the state of t			2. Date of De MARCH  4b. City, Town, or Location of Death  CATONSVILLE			08 <sup>Day</sup> 2004 <sup>Year</sup>	3. Time of Death 12:10 A.M
			, , ,							4c. County of Death BALTIMORE	
	Funeral Director		611-64 1/70 4 31			ast birthday) Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of 8 Months Days Hours Min. APRIL			irth (21,1912)  9. Birthplece (Stete or Foreign County)  VA	
	show	٦.	Usuel Residence of Decedent  10a. State 10b. County  MD N								10d. Inside City Limits
	with the M te or 28a-f Le notifie	Director	10e. Street and Number 1509 N. MONROE				10f. Zip Code	.217	11	Og. Citizen of What Cou USA	ntry?
	ours after death with the Maryla at', or items 23s or 28s-f shov Examiner coust be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marri  3 Widowed 4 Divorced	12. Was Deced	ces? 2 X No e	i	Vas Decedent of Hi I Yes, specify Cuba		pecify Yes or No- po Rican, etc.)	14. Race - Amer Black, White Specify: BLAC	, etc.
	s I and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 is marked other than "natural" other traumatic event, its Medical Ex	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education		(Give life. L	lent's Usual Occupa kind of work done of DO NOT use retired	turing most of wor. )	king	16b. Kind of Business/li	
	2 should be filed with and Mental Hygiene. is marked other ther aumatic event, the h	Be Co	12 17. Father's Name (First, Middle, I			MANAG	EK CAFEII	18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	
	thould to Ment market market	2	CHARLES HARRIS  ELIZABETH LEWIS  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C							p Code)	
	Pages 1 and 2 s nent of Health ar int: If item 27 is iry or other trau		DONTE BOWLER/NE  20a. Method of Disposition  1 □ Burial 2 □ Cremation		state Cé	lace of Dispo- emetery, crem	LIZABETH sition (Name of natory or other place	9)		20c. Location - City or T	
	permit. Pages ' Department of H Important: If ite Any injury or of once.		* 4 □ Donation 5 □ Other (State 21. Signature of Funeral Service I		NEW	CATHE 22		3/12 is of Facility JA	<u> </u>	ALTIMORE, NORTON & SON	S F.H., INC
)	80 5 8		23a. Pert1 Enter the disease, or	complications that te	Ven	Do not enti				., MD 21217	Approximate
	Physician /Medical Examiner	er	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):								Interval Between Onset and Death
Division of Vital necolus, r.O. Dox 601 00,	ificate be executed g physicien and as the burial-transit	Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c Due to (c	C						
	w requires that the death certif been signed by the attending should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	months?						23d. Date of deliv	23d. Date of delivery Month Day Year
	equires that en signed b ould be deta	by		ficant conditions contributing to death but not resulting in the underlying cause given in Part I.  Appendix Vascular Assertate  1 Pres 2 C						accoluse contribute to	he cause of death?
	ding Physician: The law r h. Affer this certificate has be funeral director, page 2 sh	e Completed	25. Was case relerred to medical						24a. Was an autops perform	y prior to co death? 1 ☑ No 1 ☐ Yes	opsy findings available ompletion of cause of
	nystcia nis certi directo	To Be	examiner?	niner?							
	Attending Physician: The isr death. ector: After this certificate he by the funeral director, page	ertification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined 5 Place of Injury - At home, farm, street, factory, office 28d. Describe how injury occur.  28b. Time of finjury M 28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occur.							of Courts Alice has	
	itel or At	Certifi	4 Homicide determi	ined 288. Place of buildin	g, etc. (Specify	·)			City or Town		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To To Son	Σ	29b. Signature and title of centifier	2-				21649	1	nanch (Month)	2004
	X		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AM BANDAM BASKALAN. 3457-WIKEUS AV. Baltumoru. MD 21229								
	Sta Registr		31. Date liled (Month, Day, Year) MAR 1 0 2		egistrar's Signat	ture	だり				

State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 8 1950 Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F Yrs. 53 218-54-0141 Director Md Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at MdCarroll Sykesville Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 6520 Carroll Highlands Road 21784 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after I ☐ Yes 2√ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify.White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) LPN Department of Health and Mental Hygiene. Important: If item 27 is marked other thereny injury or other traumatic event, the MODE. nursing/health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carroll Barnes Helen McCreary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathlene Barnes (spouse) 6520 Carroll Highlands Rd., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 3-6-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examiner The law requires that the death certificate be executed HOLE physician an s the burial-tr Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending pl as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Onknown 2 🗆 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 No 1 ☐ Yes or Attending Physician: director 25. Was case referred to medical examiner?

1 Yes 2 N Be 26. Place of Death Check only one Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PN 1 🗌 Inpatient 2 Outpatient 3 DOA this funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Tatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifie 29c. License number d cause of death (Item 23a) (Tyge, Pript) 31. Date filed (Month, Day, Year) State 10 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 4:20P M March 6 Helen R. Borcherding /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City 4220 Hermitage Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year NOV 18, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🗙 F 91 Yrs Maryland Director 217-16-4448 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 4312 Parrington Road United States Items 23a death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status i filed within 72 hours after di I Hygiene. other then "natural", or Item 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 2 should be filed vand Mental Hygie Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Caroline Link Charles Weidenhammer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itsm 27 Is m any injury or other traum. 317 Hillside Avenue, Livingston, New Jersey 07039 Louise H. Ward / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3/10/2004 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 21. Signature Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR **Physician** Wee /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit certificate be executed and Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical nse . JE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 V Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 🗌 Yes 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Daughter's examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE 32. Registrar's Signature Registrar

			1 - For State Registrar	State	of Marylan	d / Depa <i>Cer</i>	artmen tificate	t of H e <i>of L</i>	ealth a Death	ind M	ental Hyg	iene <sub>9. No.</sub> 2 (	004	07217
ı	Physicia		Decedent's Name (First, Middle, Ie ]		urnett	e					2. Date of Dea Februar		2004	3. Time of Death 8:55pm M
	/Medic Examin		4a. Facility Name (If not institution, g 2614 Francis Sc						Location of	f Death			nty of Death	L
	Funeral Director		5. Social Security Number 226–30–4886	.Sex 1	7. Age (In yrs. 74	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May II,	1929	9. Birthp Cour	lece (State or Foreign tn) A
-	D		Usual Residence of Decedent		140- 63	. Town or Lo								0d. Inside City Limits
	arylar ehow	۲	MD Carr	011	106. 61	y, Town or Lo Tanes	ytown						'	1 ☐ Yes 2 ☐ No
	the M 28a-f	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	of What Coun	try?
	death with the Maryland ms 23e or 28a-f ehow		2814 Francis S	cott Key	Highwa	у		217	87			USA		
٥	after deatl	Funeral	11. Marital Status  1 Never Married 2 Married	Armed F	cedent Ever in U forces? 2X No ive	-	Was Deced 1 Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		ace - Americ lack, White, city: White	etc.
1213-0030	hours ural',	d by	3 XWidowed 4 ☐ Divorced	Year or	Dates:								Business/Inc	
ဂ်	in 72 i	Completed	15. Decedent's (Specify only highest	grade completed	<del></del>	16a. Deced (Give life. L	kind of woi DO NOT us	rk done d se retired	ation <i>furing</i> most )	of worki	ng	16b. King of	Dusinessino	ustry
7	d with giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Hor	nemak	er				Dom	estic	-
yland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La		-				_		(First, Middle, I			
<u> </u>	1 Men narke natic	P	Unknown	Tabor		10b Mailie	a Address	(Street a		etsy	l Route Number		nknowi	
Z Z	nd 2 sh lith and 27 is n r traun		19a Informant's Name/Relationship Mrs. Melissa L.		Daughter									
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hylpiene. Department of Health and Mental Hylpiene.  The many injury or other traumatic event, Ita Madical Examinar must be notified at 900ce.		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3  ↑ 4 □ Donation 5 □ Other (Spe		- Ctata   9	Place of Dispo cemetery, cren k Lawn	natory or o	ther place	9) 3	/2/2	- 1		n-City or To tore, N	
Баптітог	permit. Departm Importa any inju		21. Signature of Funeral Service Lie	ensee Jais	H	HZ S	ATGHT ykesv	fun ille	ERĀĽ	HOME 2178	& CHAP 4 (410)	EL, PA -795-1	(Box	195)
B			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that	caused the deat each line.									Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. AL	ZHEI	MER	2	DE	MEN	TI	1			Oliset allo Death
	/Medical Examiner		Sequentially list conditions,	b	o (or as a conseq	-0	.,							
	uted Insit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conseq	uence of).								
Ď,	cate be executed physician and the burial-transit		resulting in death) Last	Due to	o (or as a conseq	uence of):								
09/80	cate b	dical		d										
C. Box 6	w requires that the death certific been signed by the attending pi should be detached for use as i	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live	utcome of pregna birth 2 Feta gnant at time of d nown	Ideath 3	Ectopic pr Other (sp						Date of delive Month	ry Day Year
7	requires that the reen signed by th hould be detache	0	Part II. Other significant condition	s contributing to	death but not res	ulting in the ur	nderlying c	ause give	on in Part I.		23e. Did tol	pacco use co	ntribute to th	e cause of death?
ras,	quires n sign	ompleted by	MENINGIOM	A							1 🗆 Ye	s 2□No	3 🔲 Prob	ably 4 Denknown
унан жесого	law reas bee	piet	OSTEDARTHI	RITIS							24a. Was a	V	prior to con	osy findings available inpletion of cause of
ř	The law cate has b	Соп	LEFT HIP	FRI	ACTURE	=					perform 1 Yes		death?	2□ No
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		55/0		Othe			(Check only on			
on of	ding Phys	ion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date (Mo	Inpatient 2 e of Injury enth, Day Year)	28b. Time of Injury		8c. Injury Work	4 🗆 Nui	- 1	ne 5 Aeside 28d. Describe ho			9
DIVISION	after deatl Director:	ertification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin		ce of Injury - At hiding, etc. (Special	ome, farm, str (y)	eet, factory	r, office			28f. Location (St City or Town	reet and Nur n, State)	nber or Rura	Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death.  To the Funeral Director After this certifical completely filled in by the funeral director, to	edical C		caminer: On the	ne best of my kno basis of examina inner stated.									
	To th comp	M	29b. Signature and title of certifier	A 1			290	. License	number	00	2	9d. Date sign	ned (Month, I	Day, Year)
	( <b>i</b> .		· Kut	nh			1	00	54	. 78	0	0.3	707	レT
	4		30. Name and address of person w Dr. Wasim Fal					rpat	Tar	nevt/	own Mio	21787		
	Sta	ite	31. Date filed (Month, Day, Year)	2.	Registrar's Signa				, 101	y L(	own, IID	21/0/		
1	Registr	ar	MAR 1 0 20	104	White of the	A STATE OF THE PARTY OF THE PAR	B. 43-44							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 525AM **Physician** MARCH MAE BOYD Zocu TDA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elderco aton Manor Altonone N/A ornesis 8. Date of Birth (Month, Day, Year) Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Davs Hours 1 □ M 2 🗓 F SOUTH CAROLIN 80 MARCH Director 218-12-3619 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at 1XXYes 2 ☐ No MARYLAND BALTIMORE N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours efter death wi and Mental Hygiene. Is marked othar than "natural", or Itams 23a. 301 MCMECHEN ST **APT 401** U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) JOHNS HOPKINS UNIV HOSTESS 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic evergence. BESSIE L. SOMMERS ROLAND BOYD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2341 Edmondson Ave., Baltimore, Maryland 21223 Clyde Boyd/ Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State A □ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL 03-09-04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part1. Eftier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Due and burial-tran Due to (or as a consequence of) ed by the attending physicien detached for use as the buria P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy performed? 1 Yes 2 1 MG 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) TUNO 1 🗌 Yes 2 ER/Outpatient 3□ DOA Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 | Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital or A 24 hours after 4 Homicide To the Hospital within 24 hours a To the Funerel C completely filled in 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) completed cause of death n 23a) (Type, Print) 30. Name and address of person 32 Registrar's Signature State 0 Registrar

State of Maryland / Department of Health and Mental Hygier 00 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** narch Minnie Elizabeth Burnett 06 2004 /Medical Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner de. Nursing Havre Grace 1412ens If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) June 7, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 83 Yrs 227-14-1049 Director Virgínia Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. tnside City Limits 27 le marked other then "naturel", or Iteme 23a or 28a-f ehow treumatic event, the Medical Exercit et mast be muilled at 1 X Yes 2 ☐ No Completed by Funeral Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Weber Street 21078 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry ould be filed to define the defined other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Domestic Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should b of Health and Ments fitam 27 le marked r other treumatic e Samuel Thomason Mary Lineberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mirlyn Spoon (Daughter) 1710 Compton St., Brandon, FL 33511 Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If its
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Galax City 3/9/04 Galax, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughan-Guynn Funeral Home 201 West Center St., Galax, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetet death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed The 1 ☐ Yes 2X No 2 💢 No After this certifical funeral director, p Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: Certification: To 1 Y96 2 XNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Att within 24 hours after d To the Funeral Direct filled in by 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04 30. Name and address of p repleted cause of death (Item 23a) (Type, Print) MIM donth, Day, 82. Registrar's Signature State MAR 1 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ruth Burris March ,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1timor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Country)
Aug. 17,1927Georgia Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □**X** 76 215-28-4035 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov Baltimore 1 Yes 2 No Directo Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2606 Keyworth Avenue USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No X Specify: Completed by Specify: Black 3 K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry er than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than other treumatic event, the M 12th Pharmacy's Assistant Priv. Comp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosa Lee Poole Joseph Poole ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2503 Loyola Southway, Baltimore, Md. 21212 Mary P, James (Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If It any injury or c once. N Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem.Park 3/13/04 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md. 21. Signature f Funeral Service Licensee 22. Name and Address of Facility  ${\tt Tri-State}\ {\tt F/S/Inc.}$ 912 Third St.NW., Washington, DC. 20001 my 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Obstructive Pulmonory **Physician** Disease Chronic 30 years /Medical resulting in death) Due to (or as a consequence of) **Examiner** moner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner the attending physician and the dor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 9 Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ormeg ∕ 2 X No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3 DOA ð Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending death. investigation 1 TYes 2 □ No the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) ths 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 6, 00027315 who completed care of death (Item 23a) (Type, Print) 30. Name and address of perser 900 Caton Ave Aques Hospital Tydendo MO 32. Registrary Signature 31. Date filed (Month, Day, Year) State MAR 1 0 2004 Registrar

	1- State of Maryland / Department of Health and Certificate of Death		ne 2004 07221
Physician		2. Date of Death Month March	Day Year 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 M 2 XF 89 Yrs.	8. Date of Birth (Month, Day, Ye)	9. Birthplace (State or Foreign Country) 4 Ohio
yland	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
death with the Maryland ms 23e or 28a-f show Linual be routified at	Maryland Baltimore  10e. Street and Number 10f. Zip Code	10-	1 □XYes 2 □ No
h with I	10e. Street and Number	10g.	Citizen of What Country? U.S.A.
urs after death vurs after death vurs after death vurs after death vurs 23e	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer  1 Yes, Give Year or Dates:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0636  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and page.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	rking De	Kind of Business/Industry Epartment of ducation
and 2  and 2  The filed of the filed other event, In Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name  19. The state of the st	me (First, Middle, Maid	
Maryland Id 2 should be fill and Mental H Z7 is marked out	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Re		ty or Town, State, Zip Code)
e, Mart and 2 Health a Health a em 27 list	Clarice Gardner / Goddaughter 8004 Woodgate Ct. #A,  20a. Method of Disposition (Name of		Maryland 21244 Location - City or Town, State
Baltimore, oermit. Pages 1 ar Department of Hea morpatent: If item any injury or other page.	1 XBurial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  1 XBurial 2 Cremation 3 Removal from State Arbutus Mem. Pk. Ceme.		timore, Maryland
Balt Permit. Departit Importations any injury once.	21. Industry of Funding Services Licensee 22. Name and Address of Facility	Derrick C	Jones F/H. P.A.
	23a. Pert1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner	disease or condition resulting in death)  a. RESULTATORY PALLURE  Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Congestive Heart Toccus  Due to (or as a consequence of):	re	
68760, ficate be executed physician and stifle burial-transit edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last    C. Rena Facture  Due to (or as a consequence of):		
68760, ifficate be ex g physician as the burial edical Ex	d		
O. Box ( ne death certi the attending hed for use a			23d. Date of delivery Month Day Year
cords, P. ( w. requires that the speed signed by should be detacted by Physical Cords)		23e. Did tobacc	o use contribute to the cause of death?
Division of Vital Records, for Attending Physician: The law requires II after death. Director: After this certificate has been signe to be the funeral director, page 2 should be gertification: To Be Completed by	Anemia  Breust Carinoma S/P mastectomy	24a. Was an autopsy performed	
Vital F vicien: Th certificate rector, pag	25. Was case referred to medical examiner?	1 Yes 2	Ño 1□Yes 2□No
on of Vital Reding Physicien: The h. Atter this certificate his funeral director, page thon: To Be Com		lome 5 Residence	
Division C tel or Attending P ts after death. Tel Director: After ted in by the funeria	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury A thome, farm, street, factory, office	28f Location (Street	and Number or Rural Route Number,
Div itel or A itel or A itel or A itel or A itel or A itel or A itel or Itel o	4 Homicide determined building, etc. (Specify)	City or Town, Sta	are)
Hospi 4 hou Funer tely fill	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only only)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	, and due to the cause irred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To the compile	29b. Signature and title of certifier 29c. License number	29d. £	Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	3/0+/04
10	Dunion Jean 527 Linder Ave bulk	mane 90	o zma
State Registrar	BRIDER CONTRACTOR		

		-	For State Registrar	State of Marylan	d / Depai	rtment		and Me	ental Hy		/ H H L	07222
	Physicia	n	1. Decedent's Name (First, Middle, Las Sharon L. Carter	st)					2. Date of De Month		2004	3. Time of Death
9	/Medica Examine Funeral Director	er	4a. Fecility Name (If not institution, give North Arunce) 5. Social Security Number 6. S	Hospital	last birthday) Yrs.	Gler If Under 1	1000	on of Death  On O Death  Ier 24 Hrs.  S Min.	8. Date of Bir (Month, Da March	th ty, Year)		urde / plece (State or Foreign arryland
	D		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation				-		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28e-f	Director	Maryland Anne Art 10e. Street and Number	undel Gl	en Burn	10f. Zip (					izen of What Co	untry?
	ath w		306 Milton Avenu		S 42 W	210		Origin? (Spec	othy Von or No		ted Stat	
792	urs a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:		Yes, specif	ent of Hispanic fy Cuban, Mexi		lican, etc.)		Black, White	
A-R. 215-0	ithin 72 hores.	Completed	15. Decedent's E (Specify only highest gra		(Give k - life. D	aind of work O NOT use	Occupation k done during in e retired)	nost of workin	g		ind of Business/I	ndustry
Sh and 21	be filed ital Hygid of other event, I	Be	12 17. Father's Name (First, Middle, Last, Ralph Carson	)	Secre	etary		other's Name	(First, Middle		erical Sumame)	
Mary	ar ar	<u>٥</u>	19a. Informant's Name/Relationship ( Thomas E. Carter		,	•	(Street and Nur Avenue				or Town, State, Z ryland	(ip Code) 21061
e, 7	s 1 and f Health item 27 other tr		20a. Method of Disposition	1	Place of Dispos cemetery, crem	ition (Nam	e of her place)	March	11	20c. Lo	ocation - City or	Town, State
200	Pages nent of I ant: if its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	JRemoval from State	n Haver			2004		Gle	n Burnie	e, Maryland
CAR Baltimore,	permit. Pages 1 and Department of Health Importent: if Item 27 eny injury or other tr		21. Signature of Fone at Serville Lice								2100 P.A. Burnie,	Maryland
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plicetions that caused the deal one cause on each line.		sr the mode	of dying, such	as cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
*	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	b. Coras a consec b. Coras a consec	quence of):	TRA	0	DISEAS	E Y D	icae.	456	
1760,	tte be execu tysician and he burial-tra	cai	that initiated events resulting in death) Last	Due to (or as a consec								
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 🗌	Ectopic pre Other (spe					23d. Date of deli Month	very Day Year
	iuires that the signed by alid be detac	þ	Part II. Other significant conditions	contributing to death but not re-	sulting in the un	iderlying ca	ause given in Pa	art I.	1	tobacco (		the cause of death?
Vital Records,	The law requir ate has been si page 2 should I	Completed							24a. Was auto perfe 1 Yes	psy ormed?-	prior to death?	topsy findings available completion of cause of
/ita	clan: ertific actor,	Be	25. Was case referred to medical examiner?	He and all				lace of Death	(Check only	one)		
xy o	ding Physician: The law h, Atter this certificate has funeral director, page 2:	2	1 Yes 2 No  27. Mann of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		A Other: 4 = 8c. Injury at Work?	2	ne 5 Res		6 Other (Specify occurred	cify)
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	De Ole Blee of Injury At h	nome, farm, stre	eet, factory			28f. Location City or To			ural Route Number,
	ne Hospitu n 24 hours ne Funera oletely fille	Medical C		hysician: To the best of my kn miner: On the basis of examin and manner stated.						, date an	d place, and due	to the cause(s)
	To ti To ti	Σ	29b. Signature and title of certifier	abys	mb		License numb	+9	1	29d. Da	RUH- S	1. Day, Year)
	V		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, 1	Rrint)	re C	len	Burn	ie	ms ?	2004
	Sta Registr		31. Date filed (Month, Day) Year) MAR 1 0 2004	32. Registrar's Sign	ature	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [... 07223 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** March 6, Carter 2004 1:21 Α Illie Floriena /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2320 Harcroft Road Timonium Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2 X F 86 Sept. 19,1917 579-22-5080 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.

I was 27 ie marked other then "natural", or fleme 23a or 28e-f ehow ther treumatic event, the Medical Examinations to reditted at 1 ☐ Yes 2X No Baltimore Maryland | Baltimore Direct 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21239 U.S.A. 1318 Heather Hill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) loa. Decedents usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Occupational Therapist
Assistant College (1-4or 5+) Elementary/Secondary (0-12) Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Wilhelm Addie Beulah Emory Hundertmark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 le
eny injury or other treu 2320 Harcroft Road Martin Daughter Timonium, Maryland 21093 Carol 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Picemeter, crematory or other place)
Pine Grove United
Methodist Ch. Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 □ Ponation 5 □ Other (Specify) 3-10-2004 Parkton, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signa Vro of Funery Saving Licensee Bu 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): CORONAR ARTERY DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 PNo or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig MD ourelses ame and address of person who completed cause of death (Item 23a) (Type, Print) N. CHARLES TOW SON GRASSO MD

State Registrar RANCESCO

6569

		207	Please T  1 - For State Registrar	State of Marylar	nd / De	partme	ent of H		•	gien	-		0.7	2 <b>2</b> 4
	Physic	ian	1. Decedent's Name (First, Middle, Last) Corinne M. Creight	on					2. Date of D	eath	y 20	004	3. Time of 3:45	Death A M
	/Medi Examir		4a. Facility Name (If not institution, give s			4b. Cit	ty, Town, o	r Location of Dea			. County		3.43	- A
	-20	8	Hospice of Baltimo	re Gilchrist	Cent	er T	owson			В	altin	nore		
10	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		Month	der 1 Year is Days	If Under 24 Hrs Hours Min	(Month, D	irth a <i>y, Year,</i>	)	9. Birthpl Count	ace (State o	r Foreign
	Director		220-14-4828 Usual Residence of Decedent	80					Sept 4	, 19	23 IV	<u>vasnı</u>	ngton	DC_
	arylan show	_	10a. State 10b. County		ity, Town or	Location						10	Od. Inside Ci 1 ☐ Yes	•
	the M 28a-f	ecto	MD Baltimore	To	wson	10f 3	Zip Code			10a Ci	tizen of W	bat Count		2 20110
	after death with the Maryland or Items 23s or 28s-f show minst must be notified at	Funeral Director	615 Chestnut Avenu	e Apt 1424			204			_	SA	1121 000111		
	r deat	iner		2. Was Decedent Ever in L Armed Forces?	J.S. 1	3. Was Dec	cedent of H	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or N to Rican, etc.)		14. Race	- America		
36	rs afte	by Fu	1 ☐ Never Married 2 🖔 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specity:		İ	Specify:			
21215-0036	72 hou natura	ted	15. Decedent's Educ	ation	16a. De	cedent's Us	sual Occup	pation	ede i e e	16b. K	and of Bus	whi siness/Ind		
215	nthin 7 ne. hen "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			use retired	during most of wo	rking					
d 2	filed v Hygie other t	e Co	12 17. Father's Name (First, Middle, Last)		Homer	naker		18. Mother's Na	me (First, Middle		Home Sumame			
lan	ald be fental rked c	To B	Francis P. Harbin					Corinne				,		
AM. Maryland	2 shot and h is ma		19a. Informant's Name/Relationship (Typ					and Number or R	ural Route Numb	per, City	or Town, S	State, Zip	Code)	
			John R. Creighton  20a. Method of Disposition	/ husband	Place of Dis	position (N	lame of		Apt 1424		OWSON			<del> </del>
3:45 altimore,	ages ent of nt: If it		1 Burial 2 Cremation 3 Re 1 Donation 5 Other (Specify)	emoval from State	cemetery, c ney Va	rematory o	r other plac	· 1	0/04		onium	•	vii, otato	
の計	permit. P Departm Importar any injur		21. Signature di Funeral Service License		ricy ru			ss of Facility	0/04		050 Y	-	Road	
<b>3</b> ■	89558		Pet U.U	lug				n Funera			wson		21202	
0	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e 7 se on each line.	sw:			D ( Cons		arrest,		1	Approximate Interval Betwood Conset and E	ween Death
2004	Examiner		Sequentially list conditions.											
J.	led jist	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as a consec	quence of):									
C± 09		ai Examin	that initiated events cresulting in death) Last	Due to (or as a consec	quence of):									
MARC 30x 687	rtificati ng phy as the	Nedic	IE FEMALE.											
o	es that the death certificate I gned by the attending physi be detached for use as the t	Physician/Medic	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of constant in the constant in	ıl death 3	3 □Ectopic 5 □ Other (					23d. Date Mont		•	'ear
S, P	requires that the een signed by th hould be detache	by Pł	Part II. Other significant conditions conf	tributing to death but not res	ulting in the	underlying	cause give	en in Part I.	23e. Did	tobacco i	use contrib	oute to the	cause of de	eath?
H	w require been si should b	ted							1 🗆	Yes 2	□ No 3	Proba	bly 4 □U	nknown
CREIGHTON Vital Records, P.	aw Is b	Completed							24a. Was auto perfo 1  Yes		de	ere autop: ior to com ath? Yes 2	sy findings a pletion of ca 2 No	ivailable luse of
	Physician: this certific	To Be	25. Was case referred to medical examiner?  1 Types 2 Ano	ospital:	ER/Outpati	ent 3 0	Othe	er: 4 Nursing b	ome 5 Res		e (Ciff)thai	/Speciful	beside	2121
山 o	ng Phy ter thi neral (		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time	of	28c. Injury Work		28d. Describe				, 00,	190
三号	Attending r death.	catic	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 '	Yes 2 □ No						
ORRINE Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif					28f. Location ( City or To	wn, State	"			oer,
J	e Hosi 24 ho e Fune etely fi	Medicai	29a. Certifier (Check only one)  1 Certifying Physical Examination	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, de ition and/or	ath occurre investigation	on, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and man i place, ar	ner as sta id due to t	ted. he cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			2	9c. License	000			te signed			
			Mariane				DS	8303		Marc	48	2009	+	
	3		30. Name and address of person who con	npleted cause of death (Item	n 23a) (Typ	e, Print)	10/0-	st B	albus	00	600	7.13	010	
D.	Sta	ite	31. Date filed (Month, Day, Year) MAR 1 0 200	32. Registrar's Signa	atur	mask	SULLS.	0 ()	al"wa	الال	11/5	-16	4	
	Registr		MAR I U ZU	4 filmera.	1.5° 1	The second second								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Decedent's Name (First, Middle, Last) Dey MARCH Physician 2040 navie 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street end n Examiner If Under 1 Year 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign
 Country) **Funeral** Days Months 112-58-0497 Usuel Residence of Decedent Director Peges 1 and 2 should be filed within 72 hours efter death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No Director ti more 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Numb 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) by Funeral 12. Was Decedent Ev Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementa (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Father's Neme (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 Cedonia Ave agstaff 20a. Method of Disposition

☐Burial 2 ☐ Cremation 3 ☐ Removal from State Date 4 Depertment of H important: If Ite any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the shock, or heart tailure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical an cer Examiner consequence of): Physician/Medical Examiner Jen or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tension 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 WUnknown 1 Yes 2 No SIRONA MRONN gamage ģ Records, 24b. Were autopsy findings available prior to completion of cause 24a. Was an autopsy performed? Be Completed unknown of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 27. Megner of Death Naturel 2 ☐ Accident 5 Pending investigation Division 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examine: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) south chambes MARA 601 KIR

State Registrar Registrar's Signetur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month - 04 - 2004 ANNE JAMES CLARK **Physician** 12:07 P.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MUINOMIT BALTIMORE STELLA MARIS Birthplace (State or Foreign Country)
 NEW YORK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02-21-1922 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X 82 Yrs. 207-40-4365 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28e-f show ningranual by notified at 1 Yes 2 (No MD. BALTIMORE TIMONIUM Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 2300 DULANEY VALLEY ROAD 21093 U. S. A. Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced natural, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ROMAN CATHOLIC College (1-4or 5+)
5 PLUS Elementary/Secondary (0-12) ROMAN CATHOLIC NUN AND TEACHER SCHOOLS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAMES CLARK ANNE FITZGERALD ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SR.PATRICIA LOOME (RELIGIOUS SUPERIOR) 1531 GREENSPRING VALLEY RD.STEVENSON.MD.21153 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition SISTERS OF NOTRE DAME 03-09-2004 ILLCHESTER, MARYLAND XXBurial 2 Cremation 3 Removal from State \*4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD., 21204 R. & Beill, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) o 9☐ Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□Yes 2😿 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ို 1 ☐ Yes 2 🙀 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature State Registrar

سيرا		Registrar  1. Decedent's Name (First, Middle, Last)		partment of Health and leartificate of Death	Reg. I	No2004	3. Time of Deat
Physici	an		LENAY CROMWELL			Day Year 2004	
/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deal		4c. County of Death	T:OT E
Examin	ier	30 LIBERTY ST	silver and number)	ABERDEEN		HARFORD	
		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		8. Date of Birth		
Funeral Director			IM 20XF 16 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Coi	aplace <i>(State or For</i> untry) RYLAND
AII COLOI		Usual Residence of Decedent	1 20		APITI 24	1007 FIA	KILAND
MOI		10a. Slate 10b. County	10c. City, Town or	Location			10d. Inside City Li
ital Hygiene. id other then "natural", or items 23a or 28a'f show event, it e Medical Exactional be retified at	to	MARYLAND HARFO	RD CO	ABERDEEN			1 ☐ Yes 2 🖸
1286	Director	10e. Sireet and Number		10f. Zip Code	10g.	Cilizen of Whal Cou	untry?
88		30 LIBERTY ST		21001		U.S.A.	
38 2	Funeral		12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer	
2 2	Ē	1 X Never Married 2 Married	1 ☐ Yes 2 🔼 No		o Hican, etc.)	Black, While	
9 3	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLA	CK
ical	Completed	15. Decedeni's Edu (Specify only highest grade	cation 16a. Dec	edenl's Usual Occupation re kind of work done during most of wor	16b.	. Kind of Business/li	
. 5	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	All Ig		
1	ρ	10th grade		UDENT		N/A	
vent of the	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	len Sumame)	
	10 E	WILLIAM HENRY CR	OMWELL	SHARO	N LEE CLARK	<	
Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Ma	ling Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zi	ip Code)
P =		Sharon L. Walls/M	other 30	Liberty St., Aberd	deen, Maryl	and 2100	1
Itam 27 other tr		20a. Method of Disposition	annotant as	position (Name of ematory or other place)	Date 20c.	Location - City or T	own, State
7 or		1x□Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	emoval from State		L1-04 DAF	RLINGTON,	MADVIAN
inju		21. Signalud of Funeral Service License					
Department of Heal Important: If Itam 2 any injury or other once.		Charles &	LI PALINOU W	22. Name and Address of Facility M. C. BROWN COMMUNIT 321 S. PHILADELPHIA	TY FUNERAL	HOME P.A	MD 2100
-		23a. Part1. Enler the disease, or compli	cations that caused the death. Do not e				Approximate
		shock, or heart failure. List only or Immediate Cause (Final					Interval Between Onset and Deat
ysician ledical		disease or condition resulting in death)	Cardiac Arrhythmia				
aminer			Due to (or as a consequence of):				
	5	Sequentially list conditions,	Due to (or as a consequence of):	USIS		-	
ist	nju	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		ction of tricuspid valv	re		
and Il-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of);				
attending physicien and for use as the burial-transit	caiE						
phys.							
ding se as	Physician/Medi	IF FEMALE:	2a. If you autooma of programmy				
ultenc or us	ian	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deliv Month	rery Day Year
the a	/sic	1 Yes 2 No	4 Pregnant at time of death 5 9 Unknown	Other (specify)			,
ed by the detached		Part II. Other significant conditions cor	stributing to death but not reculting in the	underhing course gues in Dest I	22a Did tobaco	o use contribute to	the equipped death
E 8	by	Part II. Other significant conditions to	imputing to death but not resulting in the	underlying cause given in Fatti.			bably 4 DUnkr
been si	ted				1 🗆 Yes	2010 30 F10	Dadiy 4 DONKI
S CI	ompleted				24a. Was an autopsy	prior to co	opsy findings avai
ate ha	Son				performed?		2 🗆 No
certific rector,	Be (	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
· · · · · · ·	2	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	6 Ther (Speci	W SCENE
ter th		27. Manner of Death 1 ♣ Najural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time		28d. Describe how in	jury occurred	
tor: Af	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Director: J	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Str		al Route Number,
in De	Certification:		January, Jos. (Optiony)		, or . omi, ou	/	
To the Funeral Director: After completely filled in by the funer	ledicai (		sician: To the best of my knowledge, de- ner: On the basis of examination and/or				
To the F	Medi	onel	and manner stated.				
To Co	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
		TOMOL	W	OCME	MAF	RCH 7, 200	)4
		30. Name and address of person who co	impleted cause of death (Item 23a) (Type	e. Print)			

			Pleas	State of M							_egible	•
			For State	State of M	arylaric	•	ificate of			~	200	1. 07220
			1. Decedent's Name (First, Middle,	. Last)		0071	meate or	Dealit	2. Date of De		200	3. Time of Death
а	Physici		ROSEMARY			Con	WELLY		MARK	6 Day	, 200	
j.	/Medic Examin		4a. Fecility Name (If not institution,	give street and number)	1	, ,	4b. City, Town,	or Location of Dea			County of De	eath .
	LAGIIII		The Johns	Hopking 1	405%	+1	1301+	invace	6			
	Funeral		5. Social Security Number	6. Sex 7. Ac		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th v. Year)	9. E	Birthplace (State or Foreign Country)
	Director		150-30-9247	TOM ZIZIF OF	•	Yrs.			2/23/1	940	Do	ver,New Jerse
	and and	ŀ	Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loca	alion					10d. Inside City Limits
	Many -1 sh	ţō	NJ Morris		Denvi	111e						1 XYes 2 □ No
	r 28e	rec	10e. Street and Number				10f. Zip Code 07834			10g. Ciliz	en of Whal	Country?
	within 72 hours after death with the Maryland ene. than "naturel", or tems 23a or 28e-f show ha Madical Examinar must be mullified at	Funeral Director	33 North Shore F	kd.			07834			USA		
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	,	S. 13. W	as Decedent of I	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No nto Rican, etc.)	- 1	4. Race - Ar Black, W	merican Indian, hile, elc.
36	or It	by Fi	1 ☐ Never Married <b>3</b> ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		Yes XXNo				SpecifyWh	
Maryland 21215-0036	hour tural	ed b	15. Decedent	Year or Dates:		16a Decede	nl's Usual Occu	nation		16b Kir	nd of Busine	se/Industry
5	n "na	plet	(Specify only highest	t grade completed)	6.1	(Give ki	nd of work done  NOT use retire	during most of wo	orking	100.10	id of Edsirie.	samoustry
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or	3+)	Homema	ker			Home	maker	
p	al Hy al Hy othe	BeC	17. Father's Name (First, Middle, L	.ast)					me (First, Middle	Maiden .	Sumame)	
<u>ya</u>	Ment Ment arkec	은	James Buckley					A1thea	Haskel1			
Jar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28e-1 show simply or other treumatic event. The Madical Examinat must be nutified at ance.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Street	t and Number or F	lural Route Numb	er, City or	Town, State	, Zip Code)
e,	1 and Health om 27 ther t		Robert W. Conr 20a. Method of Disposition	nelly	20h PI	33 Nor	th Shor	e Rd. De	nville,			or Town, State
סַכ	nt of h		1 Burial 2 Cremation				tion (Name of story or other pla		1			or rown, State
Baltimore,	artmer artmer artant injury		<ul> <li>4 □ Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Septice L</li> </ul>		Locu		1 Cemet		1/2004		-	
Ba	Depa Impo sny i		Voalt h		00673	La capte		116	arman Fu			
ě.	945-34		23a. Part 1. Enter the disease, or o	complications that cause	d the death			urn Dr. I			MD 2	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each li SEPS								Interval Between Onset and Death
N.	/Medical		disease or condition resulting in death)	a. Due to (or as		ence of):						2 DAYS
	Examiner		Constitution and distance	h								
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):			~			
	te be executed ysicien and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
760,	be ex	cal E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as	a consequ	ience oi):						
687	phys phys s the			d					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_	-
×	death certificate e attending phys id for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy				2	3d. Date of c	telivery
Вох	death a atter	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			ctopic pregnanc Other (specify) _	y .		ny -	Month	Day Year
0	t the by the ache	hys	9 □ Unknown	9□ Unknown								
S, P	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as th	by Physiclan/Medl	Part II. Other significant condition	ns contributing to death t	out not resu	ilting in the und	lerlying cause gi	ven in Part I.	23e. Did t	obacco u	se contribute	to the cause of death?
ord	w require been si should I								1 🗆	Yes 2	(No 3□	Probably 4 Unknown
ecc	lawr as be	Completed							24a. Was			autopsy findings available o completion of cause of
<u> </u>	The ate h page	Con								rmed?	death 1 🔲 Y	?
Vital Record	clan: ertific ector.	Be	25. Was case referred to medical examiner?	11			To		ath (Check only o	one)		
of	Physic this c	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatient	3LI DOA		Home 5 ☐ Resi			pecify)
nc	Jing I	lon	1 Natural 5 ☐ Pending	(Month, Da	y Year)	28b. Time of Injury		nyat ork? ]Yes 2 □ No	28d. Describe	now injury	occurred	
Division	Attendi death. ctor: A y the fu	Certification:	3 ☐ Suicide 6 ☐ Could n	ot be 200 Place of In	iury - Al ho	me, farm, stree			28f. Location (	Street and	l Number or	Rural Route Number,
Ö	after after Direct	erti	4 - Homicide determine	building, e	tc. (Specify	)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		,
	Mospitel 24 hours Funerel etely filled	<u>a</u>	29a. Certifier 1 Certifying	g Physician: To the best	of my knov	wledge, death o	occurred at the t	ime, date and place	e, and due to the	cause(s)	and manner	as stated.
	To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical E	Examiner: On the basis of and manner st	of examinati	ion and/or inve	stigation, in my	opinion, death occ	urred at the time,	date and	place, and d	ue to the cause(s)
	To the within 2	Ž	29b. Signature and title of certifier					se number				nth, Day, Year)
	~		100	MD			KE	5-000	)	MAR	-H 6	2004
	3		30. Name and address of person v								7000	
			RITA RASTOGI	600 NORT			TREET	BALTIMU	EE IVID	212	<u>ځ ا</u>	
	Sta Registi		31. Date filed (Month, Day, Year)  MAD 1 0 2004	JZ. Hegisi	rar's Signat		alls!					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year February 29, 2004 Physician Sadie Crago 8:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner FREDERICK Northampton Manor Health Care Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) June 25, 1 Birthplace (Stete or Foreign Country)
 Canada 5. Social Security Number **Funeral** 1□M 2X F Days 85 Yrs 1918 Director 281-10-3700 Usuet Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "naturel", or frams 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1)X Yes 2 □ No OH Cuyahoga Garfield Heights Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5001 Claremont Blvd. 44125 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryiand 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3₹ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Cafeteria Manager Art Museum 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sophie Jordan Walter H. Gosse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 407 Spring Gate Court Mt. Airy, MD Robert Norman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 3/4/04 4 ☐ Donation 5 ☐ Other (Specify) Bedford Hts., Ohio 22. Nama and Address of Facility Rybicki & Son Funeral Home 21. Signature of Funeral Service Licensee 4640 Turney Road Garfield Heights, Ohio 44125 23a. Part I Little the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cerebrousseulas Years Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vitai Records, P.O. Box 68760 Due to (or as a consequence of): ned by the at e detached fo Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🍇 Unknown P. sease Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of deeth? pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 \_\_ tnpatient 2 \_\_ ER/Outpatient 3 \_\_ DOA ို 1 Yes 2 No After this of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No I Director; Af 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tolum MO MO 51610 30. Name and address of person who completed cause of death (ttem 23e) (Type, Print) MO 21702 Mike MD Tolino 1475 Tawru

State Registrar **DHMH 16 Rev 6/95** 

31. Date filed (Month, Pay, Y

ORIGINAL

32 Registrer's Signature

PAS.

2004

			For State Registrar	State of Ma		partment of He ertificate of D		f	Reg. No. 200	
	Physic		1. Decedent's Name (First, Middle	Last)  W. DOWEL	r.			2. Date of Dea Month March	Day Year 4, 2004	3. Time of Death 12:05P M
	/Med Exami		4a. Facility Name (If not institution,		<u> </u>	4b. City, Town, or I		ilai Cii	4c. County of Dea	
		3,	Upper Chesape			Bel Air	If Under 24 Hrs.	0.0 / 8:4	Harfor	
	Funeral Director		5. Social Security Number 219-34-2648	1 <b>X</b> M 2□ F	e (In yrs. lest birthda Yrs	Months Days	Hours Min.	8. Date of Birt (Month, Day		rthplece (State or Foreign country)
	700 AF		Usuel Residence of Decedent	· ·	65			9/1/	938 NO.	10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow	5	10a. State 10b. County  MD Harfo		10c. City, Town or	st Hill				1 Yes 2 No
	the M	recto	MD Harfo	o E (1	rores	10f. Zip Code			10g. Citizen of What C	
	th with 23a or	i Di	2720 Chestnu	t H <b>ill</b> Roa	ad	210	050		USA	
981	ㅎ 을 됨	by Funeral Director	11. Marital Status  1 Never Married 2000 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  ad 1 Yes 2 1 Yes. Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cubar  1 ☐ Yes 2 →   2 →	spanic Origin? (Spanic Origin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
کے کر	72 hou	Completed	15. Decedent	's Education t grade completed)	16a. De	cedent's Usual Occupa ive kind of work done do e. DO NOT use retired)	ition furing most of work	ing	16b. Kind of Busines	s/Industry
26	Med.	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)				Construc	rtion
0	be filed wit tal Hygien d other the		7 years 17. Father's Name (First, Middle, I	Last)	BII	ck layer	18. Mother's Name	e (First, Middle,	Maiden Sumame)	201011
2	y car	To Be	Velter Dowe	11		7	Vinnie	Jone	s	
2	d 2 should the and Mer 7 is market traumatic	-	19a. Informant's Name/Relationsh			alling Address (Street a				
7	s 1 and 2 if Health item 27 i		Ruth A. Dowel	.l- wife		20 Chestni		rd.,F	orest Hi.	
5/4/04  ACC	permit. Pages 1 Department of H Important: if ite eny injury or ot		20a. Method of Disposition  1XXIII 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)  21. Signatule of Funeral Service	pecify)	1	sposition (Name of crematory or other place r Mem.Gd)  22. Name and Address	ns 3/9		Bel Air,	
ď	permit. Departi		Michaelt:	Tillett		HarkinsF	.н., 60	0 Main	St.,Del	ta,PA 17314
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused only one caused in each line	f the death. Do not ne.	enter the mode of dying	g, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between Onset and Death
	/Medica Examine		resulting in death)	PNE	~	- /				IIDAXS
~ L	ob/ou, titicate be executed g physicien and as the burial-transit	dicai Examiner	Sequential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· CHRO	a consequence of):	STRUCTIVE	E PULM	ONARY	DISEASE	Year
	ath cer	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
•	luires that the de n signed by the a	þ	Part II. Other significant condition	ons contributing to death b	out not resulting in th	e underlying cause give	en in Part I.		obacco use contribute Yes 2 □ No 3 🕱	to the cause of death?  Probably 4 □Unknown
	A. DIVISION OT VITAL MECONAS, pitel or Attending Physicien: The law requires lurs after death.  In after death.  In a piter or: After this certificate has been signs lifed in by the funeral director, page 2 should be.	Completed						24a. Was autor perfo	psy prior to ormed? death	autopsy findings available completion of cause of
S ?	/ITA	Be (	25. Was case referred to medical examiner?			Otho	26. Place of Deat			
James	A LIVISION OT VITAL MEGINE TO the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendir 2 Accident investi			ie of 28c. Injury	4   Nulsing no		dence 6 Other (Sp how injury occurred	pecify)
Sowell,	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could 4 Homicide determ	inna Zee. Place of in	jury - At home, farm tc. (Specify)	, street, factory, office		28f. Location ( City or To	Street and Number or I wn, State)	Rural Route Number,
DC 2	the Hospitel hin 24 hours a the Funerel mpletely filled	Medical (	29a. Certifier Check only one) Certifyir	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/o	or investigation, in my op	pinion, death occur	and due to the red at the time,	date and place, and d	ue to the cause(s)
•	1	Σ	29b. Signature and title of certifie	gun	ms	2000	344		29d. Date signed (Mo	1, 100 4
	V		30. Name and address of person  Patricia Gu  31. Date filed (Month, Day, Year)	rney MD,		rpe, Print) Chesapeake	e Medic	al Cen	ter, Bel	Air,MD
	Regis		MAR 1 0	A.C.	and Signature	Grade)				
		001			ORIG	INAL				

			For State Registrar	State of Ma	•		tment of He ificate of D		lental Hyg	giene leg. No. 20	04	07231
745			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith	Year	3. Time of Death
	Physici /Medic		MILDRED H. D	IGGS					March	3 200		11:19 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s.	treet and number)			4b. City, Town, or L	ocation of Death		4c. County o	Death	
		ы	SINAI HOSPITAL				BALTIM	ORE		N/	'A	
7	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
	Director		218-22-2342	M 241 F	74 Y	rs.			SEPT 19	1929	MZ	ARYLAND
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loca	ation				1	0d. Inside City Limits
	sho	5			•							XXYes 2 ☐ No
	Ne N 28e-f	Director	MARYLAND N/A  10e, Street and Number		BA	7T.T.T	MORE 10f. Zip Code			10g. Citizen of Wi	at Cour	ntov?
	with a or	ā		27.0			i i	L216		U.S.A.		,
	eath	Funeral	2800 TAZEWELL RO	2. Was Decedent Ev	ver in U.S.	13. W	as Decedent of His		ecify Yes or No-			can Indian,
	ther d	E.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XXX		lf '	Yes, specify Cuban	Mexican, Puerto	Rican, etc.)	Black	White,	etc.
ဗ္ဗ	urs a	þ	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	∐Yes 2 <b>XX</b> No	Specify:		Specify:	BL	ACK
Õ	2 ho	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. [	Decede	nt's Usual Occupat ind of work done du	ion	ina	16b. Kind of Bus	iness/Inc	dustry
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. other than "netural", or Items 23a or 28e-1 show ent, the Medical Erabilizat must be rollified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. Do	O NOT use retired)		9	DD 7113		
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nd	be fill d out	Be	17. Father's Name (First, Middle, Last)				1			Maiden Surname	)	
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	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Medical Exactinat treatment or other and the rotified at		LaSandra T. Diggs	/Daughter	20b. Place of 0	-	Tazewell		Date	20c. Location - C		
Baltimore,	in it of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery	, crema	atory or other place,	1				
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	蒙		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused l	death. Do no	ot ente	the mode of dying,	such as cardiac	or respiratory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	//	rule.	13	1/1	1.00			7	Onset and Death
36	/Medical		resulting in death)	Due to for as a	consequence of	0	O h	111	1		1	, /
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3.7	p #s	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to (or as a	consupernos d	1)		-			V	,
	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):						
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387	phys phys s the	dical	0									
9 X	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o						23d. Date	of delive	erv
Вох	leath atter	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other (specify)			Mont		Day Year
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<u>ت</u>		by PI	Part II. Other significant conditions con	tributing to death but	t not resulting in	the und	derlying cause giver	n in Part I.	23e. Did to	bacco use contrib	oute to th	ne cause of death?
rds	w requires been sign should be	ed b							1 □ Y	es 2 No 3	Prob	ably 4 Unknown
Records,	≥ 0 0	ompleted							24a. Was a		ere auto	psy findings available mpletion of cause of
	o - e	E							perfor	med? de	ath?	2□ No
Vital	sician: Th certificate irector, pag	BeC	25. Was case referred to medical					26. Place of Deat		A		
f <	S 5	To E	examiner? 1 ☐ Yes 2 No	lospital: 1 🔲 Inpatien	t 2XER/Out	patient	3□ DOA Other	4 Nursing Ho	me 5 Resid	ence 6 Other	(Specify	v)
0	<b>5</b> 5 6		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		ime of njury	28c. Injury : Work?		28d. Describe h	ow injury occurre	d	
sio	Attending r death. ector: After oy the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					es 2□No	00/ 1 / 0			10 11 11 11
Division of	in Die	Certification:	4 Homicide determined	28e. Place of Injur building, etc.		m, stre	et, factory, office		City or Tow	itreet and Number n, State)	or Hura	I Houte Number,
البيدا	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier  (Check only 2   Medical Exemin	sicien: To the best of								
	the Horin 24 the Fu	Medical	one)	and manner stat		201 1010	29c. License			29d. Date signed		
	To To	-	29b. Signature and title of certifier	m/11	3/1.	MI	X A	6600		2/102	1	/ /
	14		30. Name and address of person who co	impleted cause of de	ath (Item 23a) (1	Type, P	Drint)	2009		2/08	104	r
	10		Shall Land in	NEN Blin	DA PA	Op F	LESSIONIA	& blist	ling Si	to 300		
5	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature				U			
13	Regist	rar	MAR 1 0 2004	Tenera	19	1	me V. I					

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1665 Dav ANE Month Year **Physician** ARBARA 214, 2004 2:15F'M MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 KF 219.26.3605 65 Yrs MARYL ANI Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County BALTIMORE MARYLAND 1 ☐ Yes 2 No BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number MHURST A VENUE 21234 7905 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No WHITE Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TIMORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TEORGE HULE ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) USBAND ECMHURST. 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04. 4 ☐ Donation 5 ☐ Other (Specify) - PEL AIR 22. Name and Address of Facility 21. Signature of Funeral Service Licen F FUNERAL MORE, MD 21234 The HARFORD RD Approximate Interval Between Onset and Death Part I. Enter the disease, in complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lit only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSI Physician HOURS /Medical Due to (or as a consequence of): **Examiner** INTESTINAL ISCHEMIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 △No Month Year signed by the atte 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROSIS 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown peen : 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No HYPERTENSION has page 2 certificate 1 Yes 2 🗆 No Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation in my existing death occurred. 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2004 D 51852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pi. BRINKER M. Dec 7681 SL R DRIVE OWSOL MARYLIND PIEU 31. Date filed (Month, Day, Year) MAR 1 0 2004 32. Registrar's Signature State Registrar Darks

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1	State Stete Registrer	te of Maryland	Department of Hea		al Hygiene	2006	07233
۳	Physicia		1. Decedent's Name (First, Middle, Last)	Dooks		M	ate of Death		3. Time of Death
A.	/Medic Examin	al	4a. Facility Name (If not institution, give street a	Dankn und number)	4b. City, Town, or Lo			County of Death	7.0
10 M	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year I	f Under 24 Hrs. 8. D. Hours Min. (A	ate of Birth fonth, Day, Year)	9. Birthp <i>Çour</i>	place (State or Foreign
	Director		216-14-3517 1□M 2 Usual Residence of Decedent	82	Yrs.	10	0-17-19	1211 MA	IRYLAND
	Manytan f show	ior	10a. State 10b. County  MARYLAND BALTIMO!		own or Location			1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	or 289-	Direct	10e. Street and Number	ORD ROAD	10f. Zip Code		10g. Cit	izen of What Cour	ntry?
	death v	Funeral Director	11 Marital Status 12. Wa	Is Decedent Ever in U.S. ned Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Specify ) Mexican, Puerto Rican	(es or No-	14. Race - Americ Black, White,	
036	urs after al', or ite	þ	1 Never Married 2 Marned 1	]Yes 2.⊠No ′es, Give ar or Dates:		Specify:		Specify: \	HITE
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28e-f show other traumatic event, the Madical Examiner count be natified at	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12)		6a. Decedent's Usual Occupatio (Give kind of work done dur life. DO NOT use retired)	on ing most of working		ind of Business/fn	
	e filed within al Hygiene. I other then "	Be Cor	17. Father's Name (First, Middle, Last)		SALES	8. Mother's Name (Firs		ECTRIC Sumame)	77.0
Maryland	should be nd Mental marked c	ToB	A VOUST JOHA 19a. Informant's Name/Relationship (Type, Pro	U DUSE	19b. Mailing Address (Street and	MYRTLE Number or Bural Bou	te Number, City o	UTTRE	COde)
	1 and 2 sho Health and Iem 27 is mother traum		CAROL PLIKEVICIUS	58	3615 OLD H	ARFORD FO	BALTI	MOREA	1D 21234
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 ◯ Burial 2 □ Cremation 3 □ Remova  4 □ Donation 5 □ Other (Specify)	al from State	e of Disposition (Name of etery, crematory or other place)		2004 PA	ocation · City or To	E M
Balti	permit. Pages Department of I Important: If it any injury or of		21. Signature of Funeral Service Licensee	Britiothe	22. Name and Address			RAL CH ORE, MI	APEL > 21234
	***		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau			such as cardiac or res			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	demonition				
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	ate be executed hysician and the burial-transit	Examiner	that initiated events	Due to (or as a consequen	ce of):			-	
8760,	cate be e cate be e chysician the buris	cai	d						<u>11 - 11 - 1157 (N)2</u>
Box 6	death certificate e attending physicid for use as the	Physician/Med	23b. was decedent pregnant	ves, outcome of pregnancy ☐Live birth 2 ☐ Fetal de	/ ath 3 ☐Ectopic pregnancy			23d. Date of delive	
.O. B	at the deatl by the atte	ysicia	in the past 12 months?	Pregnant at time of death Unknown				Month	Day Year
<u>α</u>	luires that n signed b ild be deta	þ	Part II. Other significant conditions contributions	ng to death but not resultir	ng in the underlying cause given	in Part I.	23e. Did tobacco t		he cause of death?
Records,	The law requires that rate has been signed by page 2 should be deta	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
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n of		-	27. Manner of Death 1 Natural 5 Pending		b. Time of 28c. injury a Work?		Describe how injur		<i>y</i> = 10100
Division	eatl or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 280	e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. L	ocation (Street ar City or Town, State	nd Number or Rura a)	al Route Number,
	Hospita 14 hours Funeraf tely fillec	Medical Ce	(Check only 2 Medical Examiner: C		dge, death occurred at the time, and/or investigation, in my opin				
	To the within 2 To the complex	Me	29b. Signature and title of certifier	2 10	29c. License r		29d. Da	te signed (Month,	Day, Year)
7	6.1		30. Name and address of person who complete	ed cause of death (Item 23	Ba) (Type, Print)	39297		>/ 8/0	
	\(\frac{\gamma}{\sigma}\)	ate	31. Date filed (Month, Day, Year)	E. JOPP 32. Registrar's Signature		ALTIMORI	E,M[	) 212:	34
	Regist		MAR 1 0 2004	General /s	& Sporker				

	1	For State	State	of Maryla		artment of H		d Mental Hy		2004	07236
		Registrar  Decedent's Name (First, Middle	, Last)			tinoato or i	-	2. Date of D	eath		3. Time of Death
Physician		Darwin	Herbe	ert.	Day			Februa:	ry 26	2004	04:34 A.M
/Medica Examine		a. Facility Name (If not institution,			200,	4b. City, Town, o	r Location of De	eath	4c.	County of Death	
	-	Washington Ad				Takoma			Mo	ontgome	ry
Funeral		5. Social Security Number	6. Sex XXM 2☐ F	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	12/05	irth lay, Year),	9. Birth	place (State or Foreign nto) Jersey
Director	_	213-08-9207 Usual Residence of Decedent							7 20		ociscy
yland	Ī	10a. State 10b. County			City, Town or Lo						10d. Inside City Limits
e Mar	000	MD P.G	•	H	yattsv	ille					1 Yes 2 □ No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?
s 23s	20	1102 Parker		cedent Ever in	116 121		0782	/Specify Ves or N	0-	U.S.A.	can Indian
	by runeral	Marital Status     Never Married 2 X Marri     Widowed 4 □ Divorced	Armed F	Forces? 25 No Give	1	f Yes, specify Cuba	Specify:	? (Specify Yes or N uerto Rican, etc.)		Black, White,	, etc.
2 hou atura		15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation		16b. Ki	ind of Business/Ir	ndustry
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id be file lental Hy ked oth	ne De	17. Father's Name (First, Middle, I	Last)					Name (First, Middl	e, Maiden	Sumame)	
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Mar d 2 sh d 2 sh th and th and traum traum	1	19a. Informant's Name/Relationsh Karen Y. Day				•		NE #302	-		20019
Te, 1 and 1	-	20a. Method of Disposition				sition (Name of natory or other place		Date		ocation - City or T	
Pages Pages ent of nt: If i		1 ∑Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)						/06/04	Lan	dover	MD
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as	-	21. Signature of Funeral Service I		1	22	. Name and Addre	ss of Facility				NII.)
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death certificate the attending physical for use as the	Pnysician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre- birth 2 F	etal death 3	Ectopic pregnancy	/		:	23d. Date of deliv Month	rery Day Year
he deg	SIC	1 Yes 2 No	4□Preg 9□ Unk	gnant at time o mown	of death 5	Other (specify) _					
requires that the de-	7	Part II./Qther significant condition	ons contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to t	the cause of death?
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ecord law require as been si	Completed							24a. Wa	s an	24b. Were auto	opsy findings available
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n Of ng Phy after this ineral d		27. Manner of Death  1 Natural 5 ☐ Pendin		e of Injury onth, Day Year	28b. Time o Injury	Wor		28d. Describe	how injur	ry occurred	
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DIVISION I or Attanding after death. Diractor: Afte	Certification:	4 Homicide determ	100d 200, Flat	ding, etc. (Spe	ecify)	eet, factory, office			own, State		al Route Number,
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n 24 h	Medical		Examiner: On the					occurred at the time			
To th withir To th comp	ž	29b. Signature and title of certifie	0			29c. Licens	e number M.E.		29d. Dai Febri	te signed (Month, LLary 26,	Day, Year) 2004
^		M S Co	Kell			0.01	tel -				
1/		30. Name and address of person	who completed ca	use of death (	Item 23a) (Type,	Print) 111 Pe	enn Str	eet. Balt	imor	e, Maryl	and 21201
		31. Date filed (Month, Day, Year)	wed	Registrar's Si	gnature						
Stat Registra		MAR 1 0 2	400	Sec. A	the Span	les					

VALL/	FAULK		State of Maryland / Dep 1 - State Unpend Item #23a,27,28a-f per me 6830	artment of Health and Mertificate of Death	lental Hygid	ne 200 l;	07235
	Physici	20	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		RONALD EDWARD FAULK		MARCH	5, 2004	10:10A M
	Examir	ner	4a. Fecility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
6	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	4.5	8. Date of Birth	0.814	A Dilace (State or Foreign
33	Director		218-60-2643 1 <sup>™</sup> M <sup>2</sup> F 51 Yrs.	Months Days Hours Min.	(Month, Day, Y	ear) Cou	nplace (State or Foreign untry) VA
1, 3	D .		Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or L				
	vith the Marylan or 28a-f show be notified at	ō		TIMORE			10d. Inside City Limits 1 X Yes 2 □ No
	the M	rect	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Cou	
	th with	ai Di	5697 PURDUE AVENUE	21239	.09	USA	y:
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examinar must be notified as	by Funeral Director	11. Marital Status  1 ☑Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Apped Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: VIETNAM	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BLA	, etc.
5-0	72 hc	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	16	b. Kind of Business/Ir	ndustry
121	within ne. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired) CUSTODIAN		OUCING HOL	GRUTANG
	filed with Hygiene other the		12 17. Father's Name (First, Middle, Last)	18. Mother's Name		OUSING FOR	R SENIORS
lan	a la de se	To Be	CHARLES FAULK	VERBENA I		iden Sumamej	
Maryland	AS E E	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	i Route Number, C	city or Town, State, Zi	p Code)
	ages 1 and 2 nt of Health a: If Item 27 is or other tra		VERBENA HARRIS/MOTHER 5	697 PURDUE AVENUE,	BALTO.,	MD 21239	
ore			20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Dimatory or other place)	ate 200	c. Location - City or T	own, State
Baltimore,	trment tant: tant:		'4 □Donation 5 □Other (Specify) GARRISON	FOREST V.A. 3/10,	/04 OW	VINGS MILL:	S, MD
Bal	permit. Page Department of Important: If any injury or		James G. Worten	1701 LAURENS ST.	., BALTIM	IORE, MD 2	NS F.H., INC 1217
	Physician /Medical		23a. Peri <sup>x</sup> . Enter the disease, or complications hat caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or il,atenolol,and ntoxication	r respiratory arrest,	,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, b				
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cate be executed physician and the burial-transit	xam	resulting in death) Last  C. Due to (or as a consequence of):				
8760,	cate be execul physician and the burial-trar	dicai					
Φ		edic	0.				
P.O. Box	that the death certific ed by the attending p detached for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	es that igned b	y PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ord	w requires been sign should be				1 🗌 Yes	2 ☐ No 3 ☐ Prob	pably 4 Unknown
Division of Vital Records,	has has	Completed			24a. Was an autopsy performed	d?   death?	opsy findings available mpletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
of	Physical this cal direct	2	1 Nes 2 No Hospital: Inpatient 2 ER/Outpatier  27. Manner of Death 28a. Date of Injury 28b. Time of	-E		e 6 Other (Specif	y)
on	Jing After fune	tion	1 □Natural 5 □ Pending (Month, Day Year) Injury	Work?	8d. Describe how in		
isi	Attending r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str.	_ 1F Bu	bject inges		d Route Number
Ö	s after	Certification:	4 Homicide determined building, etc. (Specify)  Jail cell		City or Town, Si Itimore, Mo	t and Number or Rura tate) 30 L Mac	lison St.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatl 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ar	nd due to the cause	e/s) and manner as si	tated. the cause(s)
	Within To the	¥	29b. Signardre and title of certifier  2 cm	29c. License number O.C.M.E		Date signed (Month, MARCH 6,	Day, Year) 2004
	10 Br.		30 Name and address of person who completed cause of death (Item 23a) (Type, ATRICIA ATOUCH VIAL PIL PE	enn Street, Baltimo	re, Marv	land 21201	
	Sta Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	all)			

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth and I Death		iene200	4 07236
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deat Month		3. Time of Death
	Physicia		Paul	D.	Find1	ey		March	9, 2004	9:30 a M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	n	4c. County of [	
	LAGIIIII	٠.	2121 Woodview Ro	ad		Finksb	urg		Carr	011
	Funeral		Sociel Security Number 6. Se	3 1 7	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		551-14-3305	ØM 2□F 81	Yrs.	Mortins Days	riours iviiri.	Nov. 27	1922	OK
	D .		Usual Residence of Decedent							40d Incide City Limite
	nylar thow		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2X No
	e Ma	cto	MD Carroll		Fink	sburg				
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	23e		2121 Woodview H	Road		210	48		U.S.	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		American I <i>n</i> dian, White, etc.
9	hours after death with the Maryland tural', or Items 23e or 28a-f show at Examinational baindified at	F	1 ☐ Never Married 2 ☑ Married	1 XYes 2 No If Yes, Give WWII		I ☐ Yes 2⊠ No	Specify:		Specify:	T.77
5-0036	Jural',	d by	3 Widowed 4 Divorced	Year or Dates:					101 101 100	White
Ϋ́	72 i	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	furing most of wor	rking	16b. Kind of Busin	ess/industry
2	hen.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)			,		Photo	Lab
7	tygie her t		17. Father's Name (First, Middle, Last)	3	Pno	tography	18 Mother's Nar	ne (First, Middle, I		Lau
and Sur	tall h	Be	_	Findley	•				_	
Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene with a fire 27 is marked other than "natural", or items 23e or 28a-1 show item 27 is marked other than "natural", or items and items ovent, it a Medical Examinar must be notified at	٦ ا	Lee  19a. Informant's Name/Relationship (7		10b Mailio	ng Address (Street a	Lou	Vera		erguson
<u>a</u>	12 sho h and 7 is m traum									
	1 and 2 Health Iem 27 i		Mrs. Rosemary I. I			Woodview sition (Name of	Road Fi	nksburg. Date	MD 2104 20c. Location - Cit	1,5
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, cren	natory or other plac				
ij	t. Pa rtmer rtant		*4 □Donation 5 □Other (Specify		and the same of th	Forest Ve				Mills, MD
39	Depariment of the post of the		21. Signature of Euneral Service Licen:	M Oonkin		. Name and Addres				
	20260		1-012000	701-13-1		ELINE FUN				4D 21136 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	. Do not ent				351,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Cong	alw	Heart	Jaules			14
22	/Medical Examiner		resulting in death)	Due to (or a) a cons	ence of):	Heart I	N			24
į,	CXAIIIIIei		Sequentially list conditions,	b. Horte	U.	lue 1	STEER	,		3900
	P = 3	Ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Ĺ					10 years
	and tran:	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	Tens					75 75 75
8760,	The law requires that the death certificate be executed site has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Ē		Due to (or as a consequ	ence or).					
876	the b	dlcal		d	<u> </u>	·				
9	ertific ling p	Me	IF FEMALE:	220. If up c outcome of pregnar	201				20.4 D. 11	4.4.8
Box	eath certifi attending   for use as	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date o Month	Day Year
0	that the death certificated by the attending podetached for use as	by Physician/Me	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	ath 5∟	Other (specify)				
<u>P</u>	d by	Ph)	Part II. Other significant conditions of	potributing to death but not resu	Iting in the u	nderlying cause giv	an in Part I	23e. Did tol	nacco use contribu	ite to the cause of death?
	ires tha signed	by	Parken		•	noonying cause giv	DITHIT GILL.	1 🗆 Ye		□ Probably 4 □Unknown
oro	w requir been si should	ted	1 to opin 3	223 27.40				2 24 25	- /	
Records,	e law has b je 2 st	Completed						24a. Was a autops	y prio	re autopsy findings available r to completion of cause of
E .		5					_	perform 1 ☐ Yes	ned? dea	Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					ath (Check only on	е)	
<u> </u>	Physic this co	ို	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier		4   Nursing r	dome 5 Leside		(Specify)
0	ng P		27. Magner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Discribe ho	w injury occurred	
Sio	Attending r death.	atle	2 Accident investigation			M 1 🗆	Yes 2 □No			
Division of	r Att ter de irect	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (St City or Town	reet and Number ( n, State)	or Rural Route Number,
	ital o	Ce								
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysicien: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the caurred at the time, d	ause(s) and manno ate and place, and	er as stated. I due to the cause(s)
	o the	Me	29b. Signature and title of certifier	0		29c. Licens	e number	2	9d. Date signed (A	Nonth, Day, Year)
	⊢ 3 ⊢ ŏ		I has At a	unlan n n		D	- 1255	0	2/10	104
,	XI		30. Name and address of person who,	completed cause of death (Item	23a) (Type	Print)	/ /		-//	<i></i>
	5		JAMES A G	UNCON M	D	7801 >	LIKE W	ID. T	OWSON	mo 2/204
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal		DF .		,		
	Regist		MAK I U ZUU4	Alle Mar Si	A STATE OF THE PARTY OF THE PAR	The state of the s				

			State of Marylan State Registrer	nd / Depa <i>Cer</i>	artment of Healt <i>tificate of Dea</i>	h and Men th	ital Hygie Reg.	ne 2004	07237
	a to the		Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Angelo Girardi				rch	8 2004	6:10 p M
	Examín		4a. Facility Name (If not institution, give street and number)		4b. Cîty, Town, or Locati	ion of Death		4c. County of Deat	
		<u> </u>	Gilchrist Center  5. Social Security Number 6. Sex 7. Age (In yrs.	last hirthday)	Towson  If Under 1 Year   If Un	nder 24 Hrs. 8	Date of Birth		cimore
	Funeral Director		5. Social Security Number 6. Sex 133-07-8859 1	Yrs.	Months Days Hou	irs Min.	(Month, Day, Ye	1919 Ne	hplace (State or Foreign untry) W York
	p ,		Usual Residence of Decedent         10a. State         10b. County         10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryland -f show fied at	ō	100.0100	ockawa					1 ☐ Yes 2X No
	288-f	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	
PM	ter death with the Marylar Items 23a or 28e-f show Instrinual be notified at	ai Di	12216 Rockaway Beach Boulevard	l	11964			United ST	l'ates
MO19	er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify kican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, White	
999	E 0 B	by Fu	1 Nover Married 2 Married 1 Nover Married 2 Married 1 Nover 1		1 ☐ Yes 2 ☐XNo Spe	city:		Specify:	White
9 g	72 hours "natural",		15. Decedent's Education	16a. Dece	dent's Usual Occupation kind of work done during	most of working	161	o. Kind of Business/	Industry
0 √ 215	within 72 ene. then "nai	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life.	DO NOT use retired)				
2 2	filed wit Hygiene other the	Con	12	Admi	nistrative A	Assistant Mother's Name <i>(Fi</i>		Sovernment	<u> </u>
Monday, MarcH 8th 2009 € 6	e d fa b	Be	17. Father's Name (First, Middle, Last) Luiqi Girardi		1	Assunta 1		uen Sumame,	
∞ <del>2</del>	should nd Men marke umatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Nu	umber or Rural Ro	oute Number, C	ity or Town, State, 2	Zip Code)
Z E	nd 2 saith an 27 is ir trau		Lou Mercorella / Nephew		llwood Court				
e,	f Hea item		20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place)	Date		c. Location - City or	
O E	Page nent o int: #		1 Burial 2 Cremation 3 Alemoval from State	•	les Cemetery	3/13/0	04 Fa	rmingdale	, New York
nday, MAR	permit. Pages Department of P Importent: If its any injury or of ances.		21. Signature of Funeral Service Litenson		2. Name and Address of F	HUD		neral Home	
010 B	997			4	107 Wilkens	Avenue,	Baltimo	ore, Mary	land 21229 Approximate
2	Physician		23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List one one cause on each line.  Immediate Cause (Final disease or condition	ation		whea			Interval Between Onset and Beath
	/Medical		resulting in death)  a. Due to (or as a conse	quence of):	·				104
	Examiner	L	Sequentially list conditions, if any leading to immediate b. Due to (or as a conse	Mu	han .				gen
	ed Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Post	1				1x year
	cate be executed obysician and the burial-transit	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a coase	quence of):					
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0	tificat ng phy as th	Medi	TE SECULIE						
Box	eath certifii attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  4 December 12 Live birth 2 Female 14 December 14 December 14 December 15 Dec	al death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
·	The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Completed by Physician/Me	1 Pregnant at time of 9 Unknown	death 5	Other (specify)		<del></del>		
Ó 9.	that the do led by the detached	Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause given in F	Part I.	23e. Did tobac	cco use contribute to	the cause of death?
OS, ds,	uires l signe	d by					1 🗌 Yes	2 No 3 P	robably 4 Unknown
03-08	w requir been s should	lete					24a. Was an	24b. Were a	utopsy findings available completion of cause of
e e	The lay ate has page 2	omp					autopsy performe 1 ☐ Yes	?   death?	s 2 No
TX III	sicien: T certifical irector, p	Be C	25. Was case referred to medical		26. 1	Place of Death (C		1110	one -
3 >	8 × 5	To		☐ ER/Outpatie		Nursing Home			KICE
July O		on:	27. Manner of Death  1	28b. Time o Injury	of 28c. Injury at Work? M 1 □ Yes		d. Describe how	injury occurred	
Sio	or:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	home, farm, st		28f	. Location (Stree	et and Number or R	ural Route Number,
Division	in Pire	Certification:	4 Homicide determined building, etc. (Special	city)	,, ,		City or Town,	State)	
DINGREDI	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I		29a. Certifier (Check only   Medical Examiner: On the basis of examiner)	nowledge, dea nation and/or in	th occurred at the time, dancestigation, in my opinion	ate and place, and n, death occurred	d due to the caus	se(s) and manner a and place, and du	s stated. e to the cause(s)
(5	To the Hi within 24 To the Fi complete	Medical	and manner stated.		2-c. License num			. Date signed (Mon	
	To To	4	29b. Signal of a title of #rither		7300	99	2	1-9-11V	•
	X		30. Name and addr ss of person who completed cause of death (Ite	em 23a) (Type	Print)	//	)	101	
	B'		TWINGS IN ACT INTUINING COMPRISE OF BEATH (IN	1 (D)					
1		tate	31. Date filed (Month, Day, Year)  32. Régistrats Signature 1 0 2004	nature	both				
	Regis	rar	WIAK I U LUUTI	-					

			1 - For State Registrar	State of Ma	aryland .	/ Depa	artment rtificate	of He	ealth a Death	ind Me	ental Hyg	iene g. No. 2	004	07238
	Physici /Medio			D. Go:	rdon						2. Date of Deat Month 3	Day 3	04	3. Time of Death 10:55PM
	Examir Funeral Director	er	5. Social Security Number 6. S	Hospital 7. Ag	e (In yrs. last	birthday) Yrs.		ltin	nore If Under 2 Hours		8. Date of Birth (Month, Day, 1 -4-	Year)	Cour	place (State or Foreign itry) imore, Md
Saitimore, Maryland 21215-0036	ermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene. nportant: if item 27 is marked other than "natural", or Items 23a or 28a-f show yor injury or other traumatic event, the Medical Examinat must be notified at nos	To Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  Md.  N/A  10e. Street and Number  20 S. Catheri  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Error (Specify only highest grave)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last, Charles E.  19a. Informant's Name/Relationship (Mozell Gordon  20a. Method of Disposition  1 Burial 2 Cremation 3 Charles E.  21. Signature of Funeral Service Licer  Lloyd M. Es	12. Was Decedent Amed Forces?  1 Yes 2 If Yes, Give X Year or Dates:  Sucation ide completed)  College (1-4or 5)  Gord (Type, Print)	Ever in U.S. No  1  20b. Place come	alti  13. 1  6a. Decee (/Give   life.    19b. Mailir  20 20 of Dispostery, crem Zio	More  10f. Zip  2  Was Deceddid Yes, specification of work  dent's Usual kind of work  con Nor use  altin  g Address  S. C.  sition (Name and	1223 ant of History (you coupat (a done d.u. a retired)  MORE (Street ar athe a of her place, m. Address	panic Origin, Mexican, Specify:  ion wing most  Cit 18. Mother  Mond Number  of Facility o	of working  ty  's Name (  DZel  r or Aural  Da  3-10	(First, Middle, A Route Number, Baltite	Bla Special Sp	What Cour  ce - Americ ck, White, fy: B1  Business/Inc  more ne)  Md City or To  rown	an Indian, etc. ack dustry  City  Code) 21223 wn, State
09790	Physician and physician and physician site purity is the purity in the p	edicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	X	SENIC a consequence E PW a consequence TAGE	Span of entropy of the second	HOCK DNAR	of dying,	such as c	ardiac or	respiratory arre	st,		21217 Approximate Interval Between Quiset and Death PY  9R3
Records, P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	ompieted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of ACUTE MU  SERSIS	23c. If yes, outcome 1   Live birth 4   Pregnant at 9   Unknown  ontributing to death bu	2 Fetal death	ath 3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		cify)	in Part I.		1 ☐ Ye	acco use conf s 2 □ No	tribute to the	ry Day Year  e cause of death?  abiy 4*5/Unknown  asy findings available upletion of cause of
DIVISION OF VITAL RE	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2.	Certification; To Be Comp	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28e. Place of Inju	Year) 28b	D. Time of Injury	М	Other: c. Injury a Work? 1 TYe	4 □ Nurs	sing Home 28	Check only one  5 Resider  d. Describe how	ed? No nce 6 Oth	death? 1  Yes  er (Specify,	2 GV No
5	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the Funeral Direction of the Funeral Dir	Medical Certi	4 [] Homicide	building, etc. ysician: To the best chiner: On the basis of and manner sta	of my knowled examination ted.	dge, death and/or inv	occurred at estigation, in 29c.	the time n my opin License r	number	place, an	d due to the cal at the time, da	state) use(s) and mate and place, d. Date signe	anner as sta and due to d (Month, D 2003 4	ated. the cause(s)  Pay, Year)
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 0 2004	-	r's Signature		books		NO	MI	0 6120	-3		

			For State Registrar		State o	of Mary	/land /		artmen tificate				lental H	ygie <sub>Reg.</sub>	/ []	04	07	239
	Dhunini		1. Decedent's Name (First, Midd	le, Last)					-				2. Date of I	Death	Day	Year	3. Time of	f Death
1 1	Physici /Medio			equi	٨								03		05	2604	10:04	, AM
7	Examin	er	4a. Facility Name (Il not institution University of Man								Location				4c. County	of Death		
		ż	5. Social Security Number	6. Sex	Medal		n yrs. last b	oirthday)	If Under	1 Year	If Under		8. Date of E	Birth			lace (State	or Foreign
	Funeral Director		174-26-3840		W 2⊠F	70	,	Yrs.	Months	Days	Hours	Min.	Jan 1	Day, Ye	1934	Penn	elace (State of etry) sylvar	nia
	2		Usual Residence of Decedent			140	0: Oit . T-										04 1	No. 1 1 - 10 -
	anylar show	_	10a. State 10b. County		0.00	10	Oc. City, To		cation sters	t or m						'	0d. Inside C	2X No
	the M	Director	MD Ba	ltim	ore			кет	10f. Zip		•			100	Citizen of	What Cour		
	with a or .	급	14940 Dover F	heo!						2113	6			log.	U.S.A		ti y i	
	ns 23	Funeral	11. Marital Status		2. Was Dec	cedent Eve	r in U.S.	13. \	Vas Deced	tent of Hi	spanic Ori	igin? (Sp	ecify Yes or I	10-	14. Rac	e - Americ		
9	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Eparters must be notified at	Fur	1 ☐ Never Married 2 ☐ Mad	ned	Armed F 1 ☐ Yes If Yes, G	2 X No			fYes,spec !□Yes :		n, Mexicar Specify:		Rican, etc.)			ck, White,		
21215-0036	iral, c	d by	3 ☐ Widowed 4 🖾 Divorced	1	Year or I	Dates:	2.5								Specif	λ. 1	White	
5-	"netu	Completed	15. Deceder (Specify only highe	it's Educa	ition completed,	)	16	a. Deced (Give	lent's Usua kind of woi DO NOT us	al Occupa rk done d	ation Juring mos	t of work	ing	166	b. Kind of B	usiness/Ind	dustry	
12	within iene. than "	m d	Elementary/Secondary (0-12)		College	(1-4or 5+)			ousew		,				Own H	lome		
<b>d</b> 2	filed Hygi other		17. Father's Name (First, Middle,	Last)					Jusew		18. Mothe	er's Name	e (First, Midd	le, Mai				
Maryland	ges 1 and 2 should be filed within to the Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, Ite Me	To Be	Raymond		Pau1	_ Co	olgan					Mary	Cath	erin	ne 0'I	)ea		
lan	2 should and Men is marke aumatic		19a. Informant's Name/Relation:						•				al Route Nun				Code)	
	of Health of Health item 27	L,		Lggs	Daug	hter					ad I		erstor	_		21136		
Ö	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		moval from	State		tery, crer	natory or o	ther place					. Location -			
Baltimore,	permit. Pag Department Important: I sny injury o		* 4 □ Donation 5 □ Other (S				Carro		remat				9, 04	-				nd
Ba	permit. Pag Department important: I sny injury o		Mark	)est	ciler	· >_		EL	INE F	UNEK	AL H	ME I	l1824   Reiste	csto	own, l			136
			23a. Parl . Enter the Asease, of shock, or heart failure. Lis	r complica t only one	ations that cause on	sed the	e death. Do	o not ent	er the mod	e of dying	g, such as	cardiac	or respiratory	arrest,			Approximat Interval Bet Onset and	tween
	Physician		Immediate Cause (Final disease or condition	_ a.	M	Esin	enic	ij	of emia								Onset and	Death
	/Medical Examiner		resulting in death)		Due to	(or as a c	onsequence	e of):									481	11
		اة	Sequentially list conditions, if any, leading to immediate	b.	Due to	o (or as a c	onsequence	e of):			-					-		
	nted I Insit	를	Cause (Discase or injury	<				,										
ć	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c.	Due to	(or as a c	onsequenc	e of):										
8760,	2 > 2	cal		d.														
9	death certifica a attending ph d for use as th	Physician/Medical	IF FEMALE:	7											1			
Вох	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	230	1 Live		Fetal dea		Ectopic pr							te of delive		Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9□Unkr	nant at tim nown	e of death	5∟	Other (sp	ecify)							- <b>-</b> ,	
P.0	that the de ned by the a detached f		Part II. Other significant conditi	ions contr	ributing to	death but n	ot resulting	in the u	nderlying c	ause give	en in Part I		23e. Di	tobac	co use cont	ribute to th	ne cause of c	death?
Records,	w requires that s been signed t should be det	Completed by	Abolomine a-	1 hor	racci	40ti	41	eury	5 100				12	Ýes	2 🗆 No	3 Prob	ably 4 🔲	Unknown
00	w req	lete						,					24a. W	ıs an	24b.	Were auto	psy findings	available
Re	The law ate has I page 2 s	m o											pe	opsy	12	prior to cor death?	mpletion of a 2□ No	ause of
Vital	an: T	0	25. Was case referred to medica	al							26. Place	of Deati	1 ☐ Yes		(40 )	1 1 1 1 8 3	20 140	
Ž	Physician: this certificanal director, it	To B	examiner? 1 □ Yes 2⊠ No	Но	spital:	Inpatient	2 🗆 ER/0	Outpatien	t 3□ DC	A Othe			me 5□Re		e 6 □Oth	er (Specify	1)	
n of	ng Pt fter tt ineral	Ë	27. Manner of Death 1 Natural 5 ☐ Pendi	na	28a. Date (Moi	of Injury oth, Day Yo	ear) 28b	. Time of Injury	2	8c. Injury Work	at (?		28d. Describ	e how i	injury occur	red		l l
Sio	Attending r death. ector: After by the fune	catl		igation					М		Yes 2□			10.				
Division	after d Direct Direct	Certification:	4 ☐ Homicide determ	mined		e of Injury ding, etc. (	- At home, Specify)	farm, str	eet, factory	r, office			28f. Location City or 1			er or Rura	I Route Num	iber,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifyi  Check only 2 Medica	ng Physic I Examine	er: On the	ne best of n basis of ex nner stated	amination a	ge, deatl and/or in	occurred restigation,	at the tim , in my op	e, date ar	nd place, ith occurr	and due to the	e caus	e(s) and ma and place,	anner as st and due to	ated. the cause(s	;)
	Fo the within Fo the comple	Med	29b. Signature and title of certific	er er		ſ	)		290	. License	number			29d.	Date signe	d (Month,	Dey, Year)	
	->-0		1	1	1		_ m	D		814	1550				3/5	104		
	10		30. Name and address of persor	who com	pleted cau	use of deat	h (Item 23a			4				L	- (/			
	3		Laurie Punch	165	1	worth	Rd.	136	Himore	MD	21	218						
	Sta Regist	ate	31. Date filed (Month, Day, Year MAR 1			Registrar's	Signature	C.	A sa									
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State of Maryland / Departr	ment of Health and	d Mental Hygiene	2	U	U	į

07240 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Guill **Physician** 07:00 A M Giloria 02 March 2004 Francis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harbor Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🖫 F 218-18-3997 79 June 11, 1924 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ral', or Itama 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Brooklyn Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 613 Hammond Lane 21225 USA "natural", or Itama 23a death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X fited within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White þ 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then." Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If itam 27 is marked other than any injury or other traumatic event, Ital. 2006. Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Michaels Adele (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7944 North Road North, SC Louis D. Gill - Son 29112 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Riverside Cemetery 3-6-04 North, SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Culler & McAlhany Funeral Home Hlew 4541 Savannah Hwy. North, South Carolina 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 3 days Sepsis **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 6 days Pneumonia Sequentially list conditions, if any, leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Year Month Day ŏ in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Vascular Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Arterios derotic cardio vascular Disease page 2 autopsy performed? has 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Mellitus type II 2 🖾 No Diabetes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) director, Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို within 24 hours after death.

To tha Funaral Diractor: After thi completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 02, 2004 Cha RES OO 1 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover St. Baltimore MD 21225 Tan Min Chen 3001 South 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 1 0 2004

			1 - For State Registrar AMEND ITEM #2		larylan G829 3	d / Depa 3/10/ <b>0</b> ⁄e <i>u</i>	ırtment <b>1</b> ificate	t of H	ealth a Death	and M	lental Hy		2004	07241
	Physici /Medic		1. Decedent's Name (First, Middle, Las Sara S. Goldste	ein 							2. Date of D Month March		2004 <sup>Year</sup>	3. Time of Death 12:40A. M
E.	Examir	er	4a. Facility Name (If not institution, give National Lutherar	n Home		to a history		kvil.	Location o				County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 11 Control of Decedent 12 Control of Decedent	M 2√2 F 7. A	ge (in yrs. i	90 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D July26	, 1913	9. Birthp Cour Penns	alace (State or Foreign Sylvania
,	e Maryland Be-f show	Director	10a. State 10b. County Maryland Montgome	ery	10c. City	y, Town or Loc Roc	cation Ville	9					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 2	ral Dire	10e. Street and Number 6111 Montrose Roa				10f. Zip 6	Code 352				-	en of What Cour ed State	•
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event. The Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 【文Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Dayes 2 If Yes, Give Year or Dates:	?  No	li li	Vas Decede Yes, speci □ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		4. Race - Americ Black, White, Specify: W	
21215-0036	I within 72 ho iene. r then "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	de completed) College (1-4or	5+) -4	16a. Deced (Give life. L	kind of worl OO NOT use	k done d	uring most	of work	ing		of Business/Ind	•
Maryland 2	should be filed nd Mental Hygi marked other amatic event, I	To Be C	17. Father's Name (First, Middle, Last) Ephraim			Syl			Rose		(First, Middle	, Maiden S	Sumame) Fo	ox
-	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (T Leon G. Goldstein	ype, Print) —husband		6111	Mont	rose	Rd.,	r or Rura #82	1 Route Numb 20 Rock	oer, City or Ville	Town, State, Zip , Maryla	code) and 20852
Baltimore	Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	5	l ce	lace of Disposemetery, crem unt Let	atory or oth Danon	ceme	etery	3/5		Adel	ation - City or To phi, Mar	ryland
Ba	permit. Departm Importa any inju		21. Signature of Funeral Service Lice 1999  22. Name and Address of Facility  Donald V. Borgwardt Fune  4400 Powder Mill Rd. Bel  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respirator								Funeral Belt	al Ho	me, P.A. e, Mary	land 20705
ſ.	Enysician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	ine.	sto	9	Q.	ul	en	2			Interval Between Onse and Death
	cate be executed XX physician and XX ithe burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	b. Dur to (or as Due to (or as d.	a consequ	ience of!	o he	an]	R	ul	ure			sweeks 2 days
	The law requires that the death certifica lie has been signed by the attending proage 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23	d. Date of deliver	ry Day Year
rds, P	equires that en signed b		Part II. Other significant conditions co	multing to death t	out not resu	alting in the un	derlying car	use giyer	n in Part I.			obacco use		e cause of death?
al Reco	: The law re cate has be ; page 2 sho	Completed	cerebre	volcu	llar	di	sea	2Q_		_	24a. Was auto perfo 1 🗆 Yes		prior to com death?	isy findings available inpletion of cause of
Division of Vital Record	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Da	ıry	ER/Outpatient 28b. Time of Injury		Other c. Injury : Work?	4 D'Hur	sing Hon	(Check only one 5 Resident Res	dence 6[	□Other (Specify,	
<u>N</u>	oital or Att urs after de eral Direct		3 Suicide 6 Could not be determined	building, e	tc.*(Specify	)				Į.	City or To	wn, State)	Number or Rural	
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exami	iner: On the basis of and manner st	of examinati	viedge, death ion and/or inve	estigation, i	п ту орі	nion, death	place, a occurre	and due to the ed at the time,	date and pl	lace, and due to	the cause(s)
	7 wit		29b. Signature/and title of certifier	). Kar	esh	0	1	License 2	172	6		MAR MAR	signed (Month, E	
			30. Name and address of person who concludes W. Karesh	n, M.D. 26	5033 I	Ridge F		)amas	scus,	Mar	yland 2	20872		
*	Sta Registr		31. Date filed (Month, Dey, Year)  MAR 1 0 2004	82. Registi	ar's Signati	de se	2							

			For State	Please	State of M			nt of H	lealth a		l Hygie	ne	04	0721.2
			Registrar  1. Decedent's Name (Firs	t, Middle, Lasi	<u> </u>		Certifica	ile or i	Jealii		e of Death			3. Time of Death
N	Physicia /Medic		Theresa	Hartlar	nd					Mod	wich		OD4	7:05 A.M.
	Examin	w w/	4a. Facility Name (If not in		street and number,	4.1	11.	1	Location of	Death		4c. County of		INDEL.
	Funeral		5. Social Security Number			ge (In yrs. last b	inthday) If Und Month:	ler 1 Year	If Under 2		e of Birth		9. Birtho	lace (State or Foreign
e <sub>la</sub>	Director		202-18-2827	i,	□ M 2 🖁 F	82	Yrs.	Julys	1100.3	oct.	nth 199, Y	1921	Penn	Sylvania
	land low		Usual Residence of Dece 10a. State 10b.	County		10c. City, Tov	vn or Location						1	0d. fnside City Limits
	e Man	ctor	Maryland A	nne Arı	undel	Glen	Burnie							1 ☐ Yes 2 🙀 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Madical Example must be multified at or other traumatic.	Be Completed by Funeral Director	10e. Street and Number 400 Norman	Avenue				Zip Code 21061				. Citizen of W .ited S		
2	death	nera	11. Marital Status		12. Was Decedent	t Ever in U.S.	13. Was Dec	cedent of H	ispanic Origi	n? (Specify Ye Puerto Rican, o	s or No- etc.)		- Americ	ean Indian, etc.
36	rs after	oy Fu	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ □		Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:			2 <sup>1</sup> No	Specify:			Specify:	Whi	te
17.5	72 hou natura	ted	15. [	Decedent's Ed	ucation de completed)	168	a. Decedent's Us (Give kind of v life. DO NOT	sual Occup	ation during most	of working	16	b. Kind of Bu	siness/In	dustry
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ylan	should be nd Mental marked c	ToB	John Warnoo							Wiszew			24	0-11
S 6	d 2 she th and th and 7 is m traum		19a. Informant's Name/F				b. Mailing Addre 00 Norma			Glen Bu				21061
je,	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition	on		20b. Place	of Disposition (N	lame of		Date larch 9		c. Location -		own, State
FIE	Pages ment of ant: If it ury or o		1 Burial 2 Cre 4 Donation 5	Other (Specify	"	Metro	Cremato		2	2004	С	atonsv		, Maryland
Balt	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral	Selvice Licen	S00		22. Name Kirkle	and Addre	ss of Facility ddick Highwa	Funeral y S.E.	LHome	P.A.	2 a. Ma	21061 nvland
1			23a. Part Enter he dis shock, or heart faile	sease, or comp	olications that cause one cause on each	ed the death. Do	not enter the m	ode of dyir	ng, such as o	ardiac or respir	atory arrest		•	Approximate Interval Between
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(687	artificat ing phy e as th	Medi	IF FEMALE:							-				
Box	eath certificate b attending physion I for use as the b	Physician/Medic	23b. Was decedent preg in the past 12 month			2 ☐ Fetal dea at time of death	th 3 Ectopic		/			23d. Date Mor		Day Year
P.O.	at the de by the a tached	hysi	1 Yes 2 No 9 Unknown		9□ Unknown									
	w requires that been signed t should be det	ρ	Part II. Other significant	conditions c	ontributing to death	but not resulting	in the underlying	g cause giv	ren in Part I.	23	le. Did toba	"~		he cause of death?  pably 4 Unknown
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/ital	ysician: Th his certificate director, pag	Be C	25. Was case referred to examiner?	medical	0			-	-	of Death (Chec	k only one)			
	Physic r this corral dire	2	1 Yes 2 No		Hospital: inpa	iury 28b	Outpatient 3	DOA Ott	4   Nui	sing Home 5		ce 6 □Othe		(y)
<u>0</u>	nding Phy ath. r: After thi e funeral	ation		☐ Pending investigation	(Month, E	Day Year)	Injury M		rk? ∣Yes 2⊡N	lo				
Division of	I or Attendiation of the death.  Director: A in by the fu	Certification:	3 Suicide 6	Could not be determined	200. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, street, fact	tory, office			cation (Street) or Town,		er or Run	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C			nysician: To the besinner: On the basis and manner	of examination								
	To the within To the comple	Me	29b. Signature and title	of certifier				29c. Licens	se number	رد.	290	I. Date signed	(Month,	Day, Year)
	4		1分交	tim	M	69		15	+347	/	n	loweh	3	×004
	V		30 Name and address	person who	completed cause of	death (flem 23a	(Type Print)	ve il	lling	rond	M	0 2	ick	1.
		ate	31. Date filed (Month, D	ay Year	32. Regis	strar's Signature	Somethe)						,	
	Regist	rar	father of	- 0 5,000	8		7							

			1 - For State Registrar	State of Mary	/land / Depa	artmei			_	lvaier	_		07243
	Physici /Medic		Decedent's Name (First, Middle, Last     Emily W. Henn						2. Date of Month	Death	Dav	Year	3. Time of Death $4:00 P_t M_t$
	Examin		4e. Facility Name (If not institution, give					Location of Dea		4	c. County	of Death	
		Ш		- HUSPITA			NJ	BURN	VIE	F	MHE		NIXL
	Funeral Director		5. Social Security Number 6. Se 212-01-3219 Usual Residence of Decedent	☐M 212 F	n yrs. last birthday) 96 Yrs.	Months	r 1 Year Days	If Under 24 Hr Hours Mir		Birth $Day$ , Yea $13$ ,	1907		lace (State or Foreign try) 71and
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation						11	Od. Inside City Limits
	a-fah	ctor	Maryland Anne Ar	unde1	Glen Bur	nie							1 ☐ Yes 2∑ No
	death with the Maryland ma 23a or 28a-f ahow r muat be rediffed at	Director	10e. Street and Number			10f. Zi	Code			10g. C	Citizen of W	Vhat Coun	try?
	ath w	rall	110 Eastern Stree					061			Unit		
	ē # #	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or rto Rican, etc.)	No-		e - Americ k, White, e	
338	ours aff	þ	3√ Widowed 4 Divorced	1 ☐ Yes ZXXNo If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:			Specify	Wh	nite
#ENN/NZ5EN	should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or Ite imatic avant, the Medical Examinal	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. I	kind of we	al Occupa ork done d se retired)	uring lost of we	orking	16b.	Kind of Bu	siness/Ind	lustry
312	giene grene er the	Com	6	College (1-401 5+)	Hor	nemak	er				Own H	ome	
N P	φ = C >	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na				,	
型器	iould be Mental narked o	P	August Sternat						a Emily				
			19a. Informant's Name/Relationship (T) Dennis T. Kenney,	Jr. /Grands	on 1101	Easte	rn S	nd Number or F				2106	_
EMILLY Baltimore,	ges 1 it of H if itea or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Tellioval from State	20b. Place of Dispo cemetery, cren			1	ch <sup>Date</sup> 9,		Location - (	-	
I S	permit. Pages Department of Himportant: If ite any injury or of other	1	<ul> <li>4 ☐ Donation 5 ☐ Other (Specify)</li> <li>21. Signatur of Funeral Service Licens</li> </ul>		adowridge				2004		kridge	e, MD	)
<u> </u>	Depa Impo any i		In Liba	ugh	421	Crai	n Hw	of Facility lick Fur	Glen B	ırnie		2106	.1
68760,	Physician /Medical Examiner bhysician and bhysician and physician and the pnijal-Itansit the pnijal-Itansit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>SEPS</u> Due to (or as a co	onsequence of):  IRATIO  onsequence of):  KEBOV	n	PAG	umpr	VIA				Approximate Interval Between Onset and Death
Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certifical redath. Fourt After this certificate has been signed by the attending phy Extra funeral director, page 2 should be detached for use as th	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic p Other (sp					23d. Date Mon	of deliver	y Day Year
rds, P	quires that the de n signed by the a uid be detached f	d by Pł	Part II. Other significant conditions con HYPBRTBNS		ot resulting in the ur	nderlying o	ause give	n in Part I.		tobacco			a cause of death?
Reco	ne law require s has been sig ge 2 should b	mplete	ATRIALPER	RILATION	٧.				24a. Wi	is an lopsy formed?	pr	/ere autop	sy findings available apletion of cause of
<u>a</u>	sician: The la certificate ha irector, page 2	င်	25. Was case referred to medical						1 ☐ Yes	2 <b>X</b> N		Yes 2	2 □ No
>	ysician: is certific director,	To B	examiner?	Hospital:	2 ER/Outpatien	3 D	Other	26. Place of De	ath (Check only		6 DOthe	r (Specific	
40	ding Phys h. After this funeral di		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye.	28b. Time of		28c. Injury Work	at	28d. Describ				,
sioi	death.	inol:	2 ☐ Accident investigation	(	,	М		es 2□No					
Division	ours after de leral Director	Cert	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factor	y, office		28f. Location City or 7	(Street a own, Stat	nd Numbe 'e)	r or Rural	Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filed in b	edical	29a. Certifier (Check only one) Certifying Physical Exami	sicien: To the best of moner: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred	at the time , in my opi	, date and place nion, death occ	e, and due to thurred at the time	e cause(s	and man	ner as sta	ited. the cause(s)
	Vithii To th	×	29b. Signature and title of certifier			29	. License	number		29d. Da	ate signed	(Month, D	Pay, Year)
			A getin	mi			143	977		W) Cv	rely	5.	2004
	9		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, F	Print)	Gle	Busm	e mi				
	Sta Registra	- 34	31. Date filed (Month, Day, Year) ()	32. Registrar's	Signature	-			-		-=/		

	1-	For State Registrar	State of Maryla			nt of Hea te of De			Reg. No	2004	072	241
Physician /Medical Examiner	n il	Shirley J. Han  Fecility Name (If not institution, give  Manor Care Rux	non street and number)	· · · · · · · · · · · · · · · · · · ·	4b. City	, Town, or Loc		2. Date of De Month March	9, 2	2004 C. County of Death	3. Time of 4:45	A A
Funeral Director	02	Social Security Number 6. Sex	7. Age (In yrs		Months	er 1 Year   If l	Jnder 24 Hrs ours Min.	(Month, Da	th ay, Year 21,	9. Birthp Cour 1919 Mas	stace (State on htry) Sachus	sett
ome 23s or 28s-f show Fround be redified at		Md. Balti		ity, Town or L	Balti	MOre			10g C	itizen of What Cour	0d. Inside Ci	
ritema 23a or 28a-fel oliver must be rediffed Euroral Director	in large	3503 Putty Hill	Avenue	112		21	.234	pacify Vas or No		USA 14. Race - Americ		
Examinaria	2	Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, sp		exican, Puerl	pecify Yes or No to Rican, etc.)		Black, White,		
or than "natural, to the Medical of	отріете	15. Decedent's Edu (Specify only highest grad		(Give	b kind of w DO NDT	ual Occupation ork done during use retired) te Ager	g most of wo	rking		Kind of Business/Ind	dustry	
T of	9 17. 0	Father's Name (First, Middle, Last) Charles Johns				18.	Mother's Nar Eth	ne (First, Middle	, Maide	n Sumame)		
tem 27 tem other traum	Mı	a. Informant's Name/Relationship (T)  r. Clark J. Hanno a. Method of Disposition	n/Son	3503 Place of Disp	Putt	y Hill			re,	or Town, State, Zip Maryland Location - City or To	21234	<u> </u>
Department of Important: If the eny injury or o once.	-	1 Burial 2X Cremation 3 F 4 Donation 5 Other (Specify) Signature of Funeral Service Licens	Hi		Servi 2. Name:	ce Corp and Address of	Facility Ru	ick Tows	on I	son, Mary Funeral H Vland 212	ome, I	[nc
ysician Medical taminer	lm dis	Ba. Part1. Enter the disease, or shock, or heart failure. List shock mediate Cause (Final sease or condition sulting in death)	ications that cau ed the deane cause on each line.  A CUTE  Due to (or as a conse	evelo	ter the mo	de of dying, su	ch as cardia		rrest,		Approximate Interval Bett Onset and I	tween Death
sician and e burial-transit	Ca Ca tha	equentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last	Due to (or as a conse	equence of):	RE							
da tis	₩ IF	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic □ Other (	pregnancy specify)				23d. Date of delive Month		Year
be d		nt II. Other significant conditions co	ntributing to death but not re	esulting in the o	underlying	cause given in	Part I.		obacco Yes 2	use contribute to the		death? Unkno
page 2 should	Completed	_						24a. Was auto perfo 1  Yes		death?	psy findings ampletion of ca	availai ause d
rect a	0	. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 [	 ⊒ER/Outpatie	ent 3⊡ [	10.		ath (Check only dome 5 - Resi		6 ☐Other (Specify	v)	
ector: After this by the funeral of		Manner of Death  Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work? 1 ☐ Yes		28d. Describe				
e Funers after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Special Science)	cify)			ato and place	City or To	wn, Stai			iber,
550	edici	la. Certifier 1 X Certifying Phy (Check only 2 Medical Exami one)  b. Signature and the pretifier	and manner stated.	nation and/or it	nvestigatio	n, in my opinio	n, death occi	urred at the time,	date ar	nd place, and due to	the cause(s	;)
, [ 0	30	Name and address of person who co	Colum completed cause of death (lite	em 23a) (Type	, Print)	D-12	84	9	<u>ت</u> ير ر	ate signed ( <i>Month,</i> 3-9-04)		
Q	1 32	(14) P.M. 121	111 7/	A . 6	11	/	. /	11/15 1 NV			A1 0 0	

			For State Registrar	State of Marylan		tment of H ficate of I		ental Hygier Reg.	/ 11114	07245
K	Physicis		Decedent's Name (First, Middle, Last	)				2. Date of Death Month . I	Day Year	3. Time of Death
	Physicia /Medic	al	4a. Facility Name (If not institution, give		ins.	lb. City. Town, or	r Location of Death	100	3 2004 4c. County of Death	5:35H.M
	Examin	er	Gilchrist C	enter		TOU	uson			norō
	Funeral Director		5. Social Security Number 6. Se 117 - 50 - 2102	x 7. Age (In yrs.		onths Days	Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birth	place (State or Foreign ntry)
			Usual Residence of Decedent	10c Ci	ty, Town or Loca	tion		U 37 I		10d. Inside City Limits
	n the Maryland r 28a-f ehow motified at	JO.	10a. State 10b. County	P. Ioc. Cit	Poi	Aic	h.			1 ☐ Yes 2 ☑ No
	or 28a-	irect	10e. Street and Number	NL3	Ser	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	death with	Funeral Director	1012 JACKS	12. Was Decedent Ever in U	) 13 Wa	2 December of H	Ispanic Origin? (Spec	ofy Yes or No-	14. Race - Ameri	can Indian.
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow he Madical Examiner must be motified at	Fun	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	i	es, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F Specity:	lican, etc.)	Black, White,	
21215-0036	72 hours "natural", dical Exa	ed by	3 Widowed 4 Divorced	Year or Dates:				16b	. Kind of Business/Ir	ndustry
215-	hin 72 a. In "nai Medic	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kil	nd of work done	ation during most of workin d)	H	AAS.	,
121	7 5 E	Con	17. Father's Name (First, Middle, Last)		Sean	15tres	18. Mother's Name	(First, Middle, Maid	al Of (Y	19-
lanc	m - 0 =	To Be	Thomas	Tealon.			Maei	1	,	)
Maryland	2 should be fit and Mental Fits marked of reumatic ever	-	19a. Informant's Name/Relationship (T		19b. Mailing	Address (Street	and Number or Rural	Route Number, Cit	ty or Town, State, Zij	o Code)
ē, ≥	permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev once.		20a. Method of Disposition	(5)	Place of Disposit	ion (Name of		20c	Location - City or T	own, State
Baltimore,	Peges nent of int: If if		1 Burial 2 Cremation 3 1	Removal from State	cometery, croma lane y Val	ley Mem.	Gar. 3-13	5-04 T	monius	n, MD
3alti	ermit. Jepartn nports ny inju		21. Signature of Funeral Service Licens	500	22.1	Name and Addre	ss of Facility FOR	EST HIL	L, MD.	,
M	20200		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal	th. Do not enter	the mode of dyin	DERAL CI	respiratory arrest,	O NEW PO	Approximate Interval Between
À	Physician		Immediate Cause (Final disease or condition	a Cerebro	VASCU	clar d	usease			Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a consec						1
8	SA 1	Jer	Sequentially list conditions, if any, leading to immediate	b.	quence of):					
5:35AM	roate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	c. Due to (or as a consec	quence of):				-	
y 5	e be ex sician e burial	dical E		d						
0 9	ntificate ing phy s as the	Medic	IF FEMALE:							
3 Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta 4☐Pregnant at time of c	al death 3 E	ctopic pregnancy Other (specify)	y 		23d. Date of deliv Month	Day Year
W. O.	that the dead by the detached	hysi	in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	9□ Unknown						
	signed I	by	Part II. Other significant conditions co		sulting in the und	erlying cause giv	en in Part I.	1 Yes	co use contribute to t	the cause of death? bably 4 Aunknown
DINING SARAH Division of Vital Records.	w requi	Completed						24a. Was an	24b. Were aut	opsy findings available
SARAH BECOM	ding Physician: The law h. After this certificate has funeral director, page 2	Somp						autopsy performed 1 ☐ Yes 2 ☐	1? death?	ompletion of cause of 2 No
V ita	Attending Physician: r death. sctor: After this certific by the funeral director.	Be	25. Was case referred to medical examiner?  1 \( \text{Yes} = 2 \text{No} \) No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3□ DOA Oth	26. Place of Death		e 6 % Other (Speci	a Margine
5	ig Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur		8d. Describe how in		milespice
Sion	tendin death. tor: Aff the fur	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No	Rf Location (Street	t and Number or Rur	ral Route Number
OPHIN	after d I Direc d in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	it, factory, office		City or Town, S.		271001011371001
2	e Hospitel or Attending Reports after death  France The Control of the Control of	ical	(Check only 2 Medical Exam	ysicien: To the best of my kn niner: On the basis of examina	owledge, death o ation and/or inve	occurred at the til	me, date and place, a opinion, death occurre	nd due to the cause id at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	F > F 0		Allen	Mms		DS	8303	Mo	inch 3 20	704
	6		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P	int) mp (	060 IN. C	harles St	Balt more	MD 21204
		ate	37. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Regist	rar	<b>MAR 1 0 2004</b>	en enter	J Soft	ander				

			For State	State of Ma	ryland / [	Department of H		lental Hygi	ene	07014
			Registrar  1. Decedent's Name (First, Middle, Last)			Certificate of	Death	2. Date of Death	g. No. Z U U 4	3. Time of Death
ا الاستار العالم	Physici		EUGENE	=. A.	Ho	PKINS		MARCH (	3 , 2004	9.20 AM
	/Medic Examin		4a. Facility Name (If not institution, give	treet and number)	- 0	4b. City, Town, o	r Location of Death		4c. County of Death	
4			5. Social Security Number 6. Sec	7. Age	(In yrs. last bi	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthr	MORE  place (State or Foreign
4.	Funeral Director		161.16.7299 12	M 2□F	85	Yrs. Months Days	Hours Min.	Month, Day,	6,1919 PE	UNSYLVANIA
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location			1	Od. Inside City Limits
	a-f sh	ctor	MARYLAND HARF	ORD	BE	LAIR				¹□Yes 2⊠No
	vith the	Director	10e. Street and Number	BLVD		10f. Zip Code	2111	10	g. Citizen of What Cour	ntry?
	death with the Maryland rms 23a or 28a-f show frints. Let notified at	Funeral	10/2 JACKSON	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
36	or Ite	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1   Yes 2 □ No If Yes, Give Year or Dates:	WWIT	1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, White,	etc. HITE
21215-0036	72 hours :		15. Decedent's Edu (Specify only highest grad	cation	- Carlotte	. Decedent's Usual Occup (Give kind of work done	during most of work		6b. Kind of Business/In	dustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. DO NOT use retired	1)	F	BIKINESG F	MOMS
	e filed within al Hygiene. i other than '	Be Co	17. Father's Name (First, Middle, Last)	A.		OACCO	18. Mother's Nam	e (First, Middle, M	aiden Sumame)	ONVO
ylar	2 should be and Mental is marked of aumatic eve	ToB	WILLIAM +	topkins			CATH	IARINE	HOPKINS	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty  MAUREEN AMES	pe, Print)	198	o. Mailing Address (Street	700	al Route Number,	(000 110	21040
-	of Health of Health if item 27 or other tr		20a. Method of Disposition			of Disposition (Name of ary, crematory or other place		-	Oc. Location - City or To	own, State
Baltimore	Pages ment of ant: If it		1 ⊠Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)	>		JORIAL GARD	DENS MARC	14 13,200	TIMONIUM	
Ball	permit. Page Department of Important: if eny injury or once.		21. Signance of Funeral Server Licent	0		22. Name and Addre			NERAL CH	
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only of	ications that caused t	he death. Do				SEST HILL, I	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ne of Le	If Leg			Onset and Death
	/Medical Examiner		resulting in death)	Due to lor as a		of): 0	0 0	SEASE		10 Mai
		ner	Sequentially list conditions, if any, leading to immediate	Due to or as a			79 003	3C M 2C		gen
	ecuted and transit	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	per	fension				years
8760,	ate be executed ohysician and the burial transit	dicai E	and the second s	Due to (or as a	consequence	Oi).				0
9	tificate ng phy: as the	a	15 551111 5							
Вох	leath certific attending p	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	Fetal death		/		23d. Date of delive Month	ery Day Year
o.	to the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death	5 Other (specify)				
Ω.	es tha gned be de	þ	Part II. Other significant conditions co	ntributing to death but	t not resulting	in the underlying cause giv	en in Part I.		acco use contribute to the	
of Vital Records,	w requir been si should	Completed	- vaccigra s	VORES				24a. Was an		psy findings available
Re	The lay	ошо						autopsy perform	prior to co	mpletion of cause of
/ital		BeC	25. Was case referred to medical examiner?					th (Check only one		1/
	Phys this ral dii	5.7	1 ☐ Yes Æ No  27. Manner of Death	lospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day		Time of 28c. Injur	ry at	ome 5 Resider	~	in Hospice
ion	nding lath. r: After e funer	ation	Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	Injury Wor	rk? Yes 2⊡No			
Division	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, f (Specify)	arm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu					e, death occurred at the tir nd/or investigation, in my d				
	thin 24 thin 24 the F	Medical	one)  29b. Signature and title of certifier	and manner stat		29c. Licens			d. Date signed (Month,	
	F X F 8		9/12/2	- Alle		0 02	5205		March 4,0	
	1		30. Name and address of person who	impleted cause of	th (Item 23a)	(Type, Print)	0. (1)	2 1.1	nd 2120	(/
	Sta	ito	31. Date filed (Month, Day, Year)	6-5MC	6 /6 r's Signature	( N. Char	LL ST. 0	galte.	rio 2(20	7
	Regist		MAR 1 0 2004	Jan Maria		docedas				

Huppins, Eugene 3/3/04 2120pm

			1 - For State Registrar	State of Maryland /	Department of Health and I Certificate of Death	Mental Hygier		07247
o <sub>b</sub> ,	ν,	- Ar	Decedent's Name (First, Middle, Last	)		2. Date of Death		3. Time of Death
	Physici		Robert	T. HENNING-E	2. SR		Day Year	1:25 PM
	/Medic Examir	- 2	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	1.00.
	Exami	e	2751 AZU		JARRETS:	ille	11,9250	20
160 P	Funeral	1	5. Social Security Number 6. Se	x 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yell MAY 31 10	9. Birthplac	ce (State or Foreign
	Director		213-28-5481	M 20F 70	Yrs. Months Days Hours Min.	MAY 21, 19	533 Country	MD_
-3	Mary 19		Usual Residence of Decedent					
	72 hours atter death with the Maryland natural', or items 23a or 28a-f ehow dical Examinat must be nuitled at		10a. State 10b. County		own or Location		10d	I. Inside City Limits
	Mar	tor	MD ITARF	ord	JARRETSVIlle			1 Yes 2 No
	r 28	irec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country	/?
	3a o	0	2751 AZURY	CT.	21084		U.S.A.	
	s 1 and 2 should be filed within 72 hours atter death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturat", or items 23s or 28s-f show other traumatic event, the Madical Exeminer must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American	
10	r He	ΨĒ	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 <b>Z</b> No		o Hican, etc.)	Black, White, etc	C.
930	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔼 No Specify:		Specify: Wh	Te
215-0036	2 ho	Completed	15. Decedent's Ed	ucation 10	6a. Decedent's Usual Occupation	16b	. Kind of Business/Indus	stry
215	7 nin 7.	ple	(Specify only highest grad	Gollege (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	King		
212	within liene.	E	13+h	DIA	Deck HAND	Ť	VG BOAT	CORP.
	Hyg othe	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maid		
Maryland	ould be filed within Mental Hygiene. Parked other than	To B	Lawrence Her	ININGER	ANNA	KOCON		
7	2 should and Meni ie marke sumatic	-	19a. Informant's Name/Relationship (T		9b. Mailing Address (Street and Number or Ru		y or Town, State, Zip Ci	ode)
<u>a</u>	d2 strauth ar trau		ANG-ELINA HEN	NIN ETR	2751 AZURE CT. J.	ARR eTSUIL	LIA 210	84
a,	1 and Health em 27 ther tr		20a. Method of Disposition		of Disposition (Name of othery, crematory or other place)		Location - City or Town	
ğ	0.0		Burial 2 ☐ Cremation 3 ☐	Removal from State	otery, crematory or other place)		-	
Baltimore,	permit. Page Department o Important: If any injury or once.	d N	`4 □Donation 5 □ Other (Specify		Lucco Cemetery 3/8	13004 13	,ALIO PO	
Sal	permit. Departr importa any inju		21. Sonature of Funeral Service Licens	+ 11	22. Name and Address of Facility HARTLEY MILER - ST 7527 her Ford RS.	ella fune	cal Home Ct	tio.
	du E e a		1 June 911. 3	-cecs				
١.			23a. Paft1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. Done cause on each line.	Oo not enter the mode of dying, such as cardiac	or respiratory arrest,	i tn	opproximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	LUN	a CANCER		1	& M. His
	/Medical		resulting in death)	Due to (or as a consequent	ce of)			V
	Examiner	8	Securetially list conditions	b				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	pe of):			
	icate be executed physician and s the burial-transit	Examiner	that initiated events	C.				
ó	exection and and and and and and and and and an	EX	resulting in death) Last	Due to (or as a consequent	ce of):			
8760,	se be	ical		d				
Ö	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edi	AL.				(	
Box	res that the death certifica igned by the attending pt be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery	
ă	atte atte I for	cia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal dead			Month Da	ay Year
O.	y the	ıysi	9 Unknown	9□ Unknown				
α.	that ed b deta	ď.	Part II. Dther significant conditions co	entributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
ds,	sign Sign	d by				1 ☐ Yes	2 No 3 Probab	ily 4 🗆 Unknown
or.	w requir been si should	etec						
Records,	law las b	g				24a. Was an autopsy	prior to comp	y findings available eletion of cause of
<u> </u>	The ate P page	Completed				performed 1 ☐ Yes 2 ☑		No No
Vital	ding Physician: The law h. Atter this certiticate has t funeral director, page 2 s	Be (	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
>	ysic lis ce dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)	
of	g Pt		27. Manner of Death	28a. Date of Injury (Month, Day Year)	b. Time of 28c. Injury at Work?	28d. Describe how in	jury occurred	
<u>ö</u>	Attending r death. sctor: Atte	atio	1. ANatural 5 ☐ Pending 2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	Atte	Hic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of injury - At nome	, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural R	Route Number,
ā	afte Dir d in 8	Certification:	4   Nomedo	building, etc. (Specify)		City of Town, St	210)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely tilled in by the	aic	29a. Certifier Certifying Phy	sician: To the best of my knowled	dge, death occurred at the time, date and place	, and due to the cause	o(s) and manner as state	ed.
	24 P	Medical	(Check only 2 Madical Examone)	iner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occur	rred at the time, date a	and place, and due to th	ne cause(s)
	o th	₹	29b. Signature and tille of certifier		29c. License number	29d. i	Date signed (Month, Da	iy, Year)
	F \$ F 0		A Ahra	L	1) 2804	8	2/0/1/	
			The state of		1 3000	9	3/8/07	
	D		30. Name and address of person who o		a) (Type, Print)	8 . Ms 2	1236	
	I		21 Date filed (Month Day Year)			100)	770	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	•			
4			MAR 1 0 2004	A A	- family			
DH	IMH 17 Rev 1/2	2001		1	RIGINAL			
				O	DIGINAL			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Lilly G. Hum March 9, 2004 12:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care-Potomac Potomac Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🖾 F Director 578-52-1124 94 Yrs. October 2,1909 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Franchiston. 10a, State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Directo Montgomery Bethesda 1 Yes 2 No |Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 9906 Carnegie Terrace United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian/Chinese 1 ☐ Yes 2 ☑ No þ Specify 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Medical Pharmacy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Yen Hon Lee Kong Sam Wong 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Blo Prettyman Drive, Apt. 7201, Rockville, Maryland
20850 19a. Informant's Name/Relationship (Type, Print) James P. Hum. Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2004 Rockville, Maryland

22 Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850 March 13, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furteral Service Licenses M01356 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the delivery cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death Month Year Day 5 Other (specify) ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be Atrial Fibrillation Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ↑ ☐ Inpatient Other: 4 \( \overline{\ove 1 ☐ Yes 2 反 No Certification: To this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15236 March 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl I. Margolis, M.D. 11125 Rockville Pike, #211, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAR 1 0 2004

State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year FEBRUARY 23, 3:50 PM DIANE HAWKINS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 24 F 48 Director 577-74-6082 May 3, 1955 PA Usual Residence of Decedent \*how 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Mudical Examiner must be notified at Director 1 X Yes 2 □ No 28a-f D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3109 Naylor Rd., S.E. #302 20020 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ŏ Saitimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced 'natural', 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be fi Department of Health and Mental R Important: If Item 27 is marked of any injury or other traumatic ever once. Levi Boone, Sr. Pattie Williams Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Williams/ Daughter 4111 Southern Ave., SE 20019 Wash., DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □Donation 5 □ Other (Specify) Beltsville, Md. Chesapeake Crematory 3-2-04 permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 23a. Part 1. Enter the diseas or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR FIBRILLATION /Medical Due to (or as a consequence of): Examiner ISCHEMIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executes) Due to (or as a consequence of): Examiner transit certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): use as the burial-Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Į Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2 No detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ END STAGE RENAL DISEASE Completed 1 Yes 2 No 3 Probably 4 Hunknown PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 autopsy performed?

1 Yes 2 No certificate HIV SEROPOSITIVE Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1
☐ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2√ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending death. investigation 1 ☐ Yes 2 ☐ No in by the 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 6 filled Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25/0 D45490 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Yudhzir Gupta 106 Irving St. N.W. Suite #415 Washington, D.C. 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 1 0 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - State of Maryland / Dep Registrar  State of Maryland / Dep	artment of Health and I artificate of Death	Mental Hygier	ne 2004 07250
ì	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Elbert L. Jo:	nes	2. Date of Death	3. Time of Death
	Exami		4e. Fecility Name (If not institution, give street and number) 8911 Columbine Lane	4b. City, Town, or Location of Death Upper Marlbo	oro	4c. County of Deeth P.G.
e 19	Funeral Director		577-44-4863	Months Days Hours Min.		9. Birthplece (State or Foreign Country) 1934 NC
	he Marylad Sa-f ehow	Director		ocation Marlboro		10d. Inside City Limits  X□ Yes 2□ No
	s 23a or 2		10e. Street and Number 8911 Columbine Lane	10f. Zip Code 20772	10g. (	Citizen of What Country? $U$ . $S$ . $A$ .
9036	ours after de ral', or item Examinaria	by Funeral	1 Never Married 2 Married XXYes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show says injury or other traumatic event, the Medical Examinar must be routified at ODGs.	Completed	Container y Coccination (Container)	dent's Usual Occupation I kind of work done during most of work DO NOT use retired)  todian		Kind of Business/Industry  S. Postal Service
Maryland 2	uld be filed fental Hyg rked other ifc event,	To Be C	17. Father's Name (First, Middle, Last) Robert Lee	18. Mother's Nam	ne (First, Middle, Maide B. Arring	en Sumame)
	and 2 shoualth and M		19a. Informant's Name/Relationship (Type, Print)  Wanda Lyon – Daughter 121		ral Route Number, City	or Town, State, Zip Code) 20743
Baltimore,	Pages 1 ament of He lant; if item		4 □ Donation 5 □ Other (Specify) Riverda	matory or other place) le Crematory 2/	23/2004	Location - City or Town, Stete Riverdale, MD
Ball	Departiment important eny in		38	321 14th ST, N.	W. Wash,	ter Funeral Home DC 20011
事	Physician /Medical Examiner		Due to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Vo New Due to (or as a consequence of):  d.	y Discuse		
P.O. Box 6	death certi	Physiclan/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Hecords, F	es the	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
_	The law ate has b page 2 si	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
VItal	Physician: this certificinal director,	o Be	25. Was case referred o medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien:	Other	h (Check onlyone)	
lon or	nding Physath. r: After this e funeral di	atlon: T	27. Manne of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	- Carterioning Hos	me 5 Residence 28d. Describe how inju	
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
	the Hospi hin 24 hou the Funer npletely fill	Medical	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death a modern control of my knowledge	estigation, in my opinion, death occurre	and due to the cause(s ed at the time, date an	) and manner as stated. d place, and due to the cause(s)
	√ × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×	Σ	29b. Signature and title of certifier	29c. License number 20060456	29d. Da	ate signed (Month, Day, Year)
	'\		30. Name and address of person who completed cause of death (Item 23a) (Type. F  D. CTNC(CCV) 11345 TINDOCC	Sa. Waldo	ct mo	20403
· h	Star Registra		31. Date filed (Month, Day, Year)  MAR 1 0 2004  Registrar's Signature	Es .		

		•	1 - For State Registrar	State of Mary			of Health of Death			iene,		07251	
	Physicia /Medic Examin		1. Decedent's Name (First, Middle, Last	)					2. Date of Dea Month_		Year	3. Time of Death	
			Didicite II. Idolabety						March	Day 6	2004	11:15 a <sup>™</sup>	
		er											
	Funeral Director	lor	1 Githford Place, Apt 203  Catonsville  Baltimore  5. Social Security Number  1 M 2 F   87 Yrs.  Catonsville  Catonsville  Baltimore  8. Date of Birth (Month, Day, Year)  Months Days Hours Min.  March 17, 1916 West Virginia										
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Higgens. Important: If item 27 is marked other then "natural," or items 23a or 28a-f show any injury or other traumatic avant, the Marical Examiner mast be notified at once.		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	ocation						10d. Inside City Limits	
			Maryland Baltimore Catonsville									1 ☐ Yes 2 ☑ No	
		Irect	10e. Street and Number		10f. Zip Code					0g. Citiz	en of What Cou	untry?	
		ralD	1 Ginford Place,	Apt 203		21228						ed States	
21215-0036		To Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, et						14. Race - Americen Indian, Black, White, etc.  Specify: White		
			15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						g	16b. Kind of Business/Industry			
212			Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting							Retail/Social Services			
Maryland			17. Father's Name (First, Middle, Last)  Samuel Henshaw  Rlanche Farrell										
lan			19a. Informant's Name/Relationship (T				Street and Numb						
			Theresa Longo / N  20a. Method of Disposition		Db. Place of Disp	osition (Name	Place, C				/Land 2 ation - City or 1		
nor			1 Burial 2 TCremation 3 1	Removal from State	cemetery, cre Bayview	matory or other	er place)	3/9/0				Maryland	
Baltimore,			21. Signature of Funeral Service Licensea  22. Name and Address of Facility Hubbard Funeral Home 4107 Wilkens Avenue, Baltimore, Man						L Home,	Inc.			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the								Approximate Interval Between Onset and Death	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and point to the Funeral Director: After this certificate has been signed by the attending physician and point to the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Cavola Cavvyyth ynd  Due to (or as a consequence of):  Athevosclevoir Heart Disease  Due to (or as a consequence of):  Cavola Cavvyyth ynd  Due to (or as a consequence of):  Due to (or as a consequence of):  Cavola Cavvyyth ynd  Due to (or as a consequence of):  Due to (or as a consequence of):  Cavola Cavvyyth ynd  Due to (or as a consequence of):  Due to (or as a consequence of):										
1760,		cal	(	d									
.O. Box 68		Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1						23d. Date of delivery Month Day Year			
<u>α</u>									use contribute to the cause of death?				
Records,									24a. Was a autops perform	ned?	prior to o death?	opsy findings available ompletion of cause of	
Vital		0	25. Was case referred to medical		-		26. Plac	e of Death	1 ☐ Yes (Check only or		1 1 1 1 1 1 1 1	2 □ No	
of Vi		Medical Certification: To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5					ne 5 Hesid	sidence 6 Other (Specify)			
ion o			27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	n (Month, Day Year) Injury Work? 1 ☐ Yes 2 ☐ No					w injury occurred				
Division			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of injury - At nome, farm, street, factory, office					8f. Location (S City or Town	(Street and Number or Rural Route Number, own, State)			
	To th withir To th comp												
								803	03 3-8-0			4	
Est	9		30. Name and address of person who de Warren Isvael	MD 6569	Worth (	charle	ps st	#60	10 Bal	time	me, Mr.	21204	
et-	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 0 20	32/Registrar's	Signature	MARKED !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month KOLBE SEPHINE **Physician** 1:05 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD ILLAGE FOREST HILL D. PRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday)
Yrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 F Colorado Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Modical Exactines must be notified at 1 ☐ Yes 2 No Maryland Harford Director Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1 Colgate Drive 21050 United States buld be filed within 72 hours after death Mental Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Glorioso .. Pages 1 and 2 should be trained of Health and Menta tant: If Item 27 Is marked jury or other traumatic evi Mary Garbo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sal J. Glorioso / Brother 2502 Bounty Court, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) permit. Page Department of Important: If any injury or once. New Cathedral Cem. 3/10/2004 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Light 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or shock, or heart failure. List only iteations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Betw one cause or Immediate Cause (Final disease or condition resulting in death) Mariand Down Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Er ter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transil and Due to (or as a consequence of) P.O. Box 68760, attending physician IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 TNo 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by THE N 2 No 3 Probably 4 Unknown 1 Tyes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 31 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item #205 per fn 6829 3 25704 tas Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kramer Year Kuzabeti 3:05 AM March /Medical 2004 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayurew Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08–25–1921 **Funeral**  Birthplace (State or Foreign Country) 1 □ M **XX**F Months Days Hours 218-34-0066 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location or Items 23s or 28s-1 show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3436 Pike Ridge Rd. 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specity: 3 White 3 ☑ Widowed 4 □ Divorced Specify: "natural" Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 7th College (1-4or 5+) d 2 should be filed who and Mental Hygier 7 is marked other the Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any jiury or other traumatic events. Joseph Franklin Dove Leona Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Kramer/ Son 39 Austin Dr., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3/9/04 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lakemont Cemetery Davidsonville, MD 21. Signature 1 Euneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Examiner andidal endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Day Month Year 4 Pregnant at time of death 5 Other (specify) 0 9 Unknow Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ chronic tracheostomy ventilation, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown stage II pressure vicers, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy end stage renail disease on hemodialisis performed certificate 1 Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attanding Physician: Be 25. Was case referred t edical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 70 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cert let. 29c. License number 29d. Date signed (Month, Day, Year) March 5, 2004 RES-000 30. Name and adder of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ace nue, But hmore MI) 21224 Johns Hopkins Buyurew Medical Center

DHMH 17 Rev 1/2001

State

Registrar

SIGRID BERE, 31. Date filed (Month, Day, Year)

MAR 1 0 2004

**ORIGINAL** 

32. Registrar's Signature

			1 - State Registrar		artment of Health and lartificate of Death	Reg	ne 2004	07254
	Physicia	212	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Natalie 4a. Facility Name (If not institution, give street	Lillian and number)	Kamau  4b. City, Town, or Location of Deat		08 2004 4c. County of Death	1:30a. M
	Funeral		Joseph Richey Hos 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Baltimore    If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	(Month, Day, Y		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	10c. City, Town or L		01 25	54	IL  10d. Inside City Limits
	Maryla I ehov	tor	10a. State 10b. County  MD Baltimore					1 ☐ Yes ¾Q√No
	th the or 284 s not	Director	10e. Street and Number		10f. Zip Code	10g	Citizen of What Co	untry?
	ath w	rail	3928 Noyes Circle		21133	i v v	U.S.A.	iona tadia
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departinent of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, it a Madical Examination mant be notified at 900cs.	by Funeral	1 Never Married 2X Married 1	as Decedent Ever in U.S. med Forces?  Yes, Give par or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒ No Specify:	o Rican, etc.)	Black, White	
5-00	72 hou 'natural	eted	15. Decedent's Education (Specify only highest grade com	16a. Deci	edent's Usual Occupation  a kind of work done during most of wo.  DO NOT use retired)	rking 16	b. Kind of Business/l	
Marvland 21215-0036	d within giene. or then	Completed		ollege (1-4or 5+)	erty Management	E Ag	partment	Complex
bue	be filed ntal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		
2	should id Mer mark matic	2	Earl L. Ferguson  19a. Informant's Name/Relationship (Type, P.		ing Address (Street and Number or Ri	ral Route Number, C		ip Code)
	s 1 and 2 s if Health ar Item 27 le other trau		Haneef Wynn-Son	121	Nettleton Ct.	Baltimo	ce Md 2	1244
An-	ages 1 nt of He t: If Item		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	ematory or other place)		c. Location - City or 1	
1	permit. P Departme Importan any injuri		*4 □ Donation 5 □ Other (Specify)  21. Sit nature of Funeral Service Licensee		morial Park 3/1 22.Name and Address of Facility arch F/H West	15/04 R	andalist	OWII, MQ
() m	8888		Sumus 57	eke 4	300 Wabash Ave			21215
•	Physician		23a. Part 1. Enter the disease, or complication shick, or head lailure. List only one cau Immediate Cause (Final disease or condition resulting in death)	ns that haved the death. Do not enuse on each line.	Breast Can	c or respiratory arrest		Approximate Interval Between Onset and Death
10	/Medical Examiner			Due to (or as a consequence of):				0
1	ted nsit	Examiner	sacuer train, list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
4 K	eath certificate be executed attending physician and for use as the burial-transit	cal Exar	that initiated events	Due to (or as a consequence of):				
13 E8	rtificate ng phys		IF FEMALE:			· · · · · · · · · · · · · · · · · · ·		
TT TO BOX	the d	Physician/Med	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliments	very Day Year
0) 0	w requires that the bear signed by should be detact	þ	Part II. Other significant conditions contributed the State	ing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobad	co use contribute to	the cause of death?
Pecord		Completed				24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
イイナ Vital R	b ar a	Be Co	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 €	No 1 ☐ Yes	2 No
	Q 18	ဥ	examiner? 1 Yes 2 No Hospit	1   Inpatient 2   EN/Outpatie		lome 5 Residence		in hospice
	Attending Profession of the funeral	atlon:	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
A pivision     A pivision	in the	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	(Check only 2 Medical Examiner: (	t: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the caus arred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple(	Me	29b. Signature and title of certifier	0	29c. License number		Date signed (Month	Day, Year)
	X		Joan to	Khow ind	0005621		3/8/09	1
	V		30. Name and address of person who comple	ted cause of death (Item 23a) (Type	allmore, MO	21225	JOHN F.	TRWEN, ML
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	hastet.			

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Physiciar /Medica Examine Funeral Director	1	AVON	TAGMED								
Examine uneral irector			LASTER					Month	h 8,	y Yea 2004	5:30
irector		4a. Facility Name (If not institution, give					Location of I	Death	40	. County of De	eath
irector		2014 Braddish Ave		yrs. last birthday		imor	e If Under 24	Hrs. 8. Date of	Birth	NT / A	irthplace (State or Fo
Mo T			<b>Ж</b> м 2□ <b>F</b> 4		Months	Days	Hours	Min. (Month,	Day, Year	)	Country)
9	Į	10a. State 10b. County MD N	/A 10	c. City, Town or L BATIT	ocation TMORF.						10d. Inside City L 1- Yes 2(
3a or 28a	Direc	10e. Street and Number 2014 BRADDISH A	VENUE		10f. Zip	216	_		10g. Ci	itizen of What (	Country?
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Fur	11. Marital Status  1 \( \sum_{\text{Never Married}} 2 \sum_{\text{Married}} \)  3 \( \sum_{\text{Widowed}} 4 \sum_{\text{Divorced}} \)	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.	Was Dece If Yes, spe 1  Yes	cify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wi Specifyo pt	
then "natur the Medical I	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-4or 5+)	(Give	DO NOT u	ork done d se retired	furina most o	f working		(ind of Busines	
Mental Hygier arked other that atic event, ins	To Be Cor	17. Father's Name (First, Middle, Last) PETER LASTER		MAIN	TENAN	CE	18. Mother's MARY	Name (First, Midde BOND		UILDING n Sumame)	
7 Is mar traumat	_	19a. Informant's Name/Relationship (GLORIA LASTER/SIS		1.				Or Rural Route Nur			
ant of Health  It: If Item 27 I  y or other tra	-	20a. Method of Disposition  1 X Surial 2 Cremation 3 Cremation 5 Other (Specific	Removal from State	201 20b. Place of Disp cemetery, cre KING MEM	osition (Name	me of other place	9)	Date 13/04	20c. L	ocation - City of	or Town, State
Department Important:   eny injury o		21. Signature of Funeral Service Licen		2				JAMES A. ST., BALT			NS F.H.,
ysician Medical raminer	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter in derlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arrythmia  Due to (or as a co  Due to (or as a co  C.  Due to (or as a co	onsequence of):							Onset and Dea
	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	⊒Ectopic pi ⊒ Other (sp		ŧ			23d. Date of d Month	elivery Day Yea
6 g	2	Part II. Other significant conditions o Mitral Valve Prola							d tobacco		to the cause of deat Probably 4 Nonki
certificate has been si rector, page 2 should	Completed							pe	as an topsy rformed?	prior to death?	autopsy findings ava completion of caus as 2 No
recto	o Be	25. Was case referred to medical examiner?  1★★ 2 □ No	Hospital:	2 ☐ ER/Outpatie	nt 3 DC	Othe		Death (Check onling Home 5 Re		6 = ther/Se	00/h/) 7 +
Atter this tuneral of	- +	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	man y	the second	28c. Injury Work	at	28d. Describ			ecify) At sc
within 24 hours after death.  To the Funerel Director: A completely filled in by the filled in the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory	y, office			(Street ar Town, State		Rural Route Number,
• Funere letely fille	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of miner: On the basis of exa and manner stated.	y knowledge, dea imination and/or in	th occurred rvestigation	at the tim , in my op	e, date and p inion, death o	place, and due to the control occurred at the time	ne cause(s e, date and	) and manner a d place, and du	as stated. ue to the cause(s)
To th compl	₩e	29b. Signature and title of certifier			290	c. License	number		29d. Da	te signed (Mor	nth, Day, Year)
Ryn	1	30. Name and address of person who	completed cause of death	(Item 23a) (Tvne	, Print)	0.0	M.E.		Mar	ch 9,	2004

State of Maryland / Department of Health and Mental Hygiene 2004 072

			Certificate of Death	Reg. No.
	Physiciar /Medica		D. LESSNER	2. Dete of Deeth
1	Examine	4. Facility States (Mant institution of a street and symbol)	4b. City, Town, or I PARKV	ILLE BALTIMORE
-3	Funeral Director	218-09-6070 XXM 2□F 89	rs. last birthday) Yrs.  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 11-30-1914  9. Birthplace (State or Foreign Country) MARYLAND
	uth with the Maryland 23a or 28a-f ahow ust be notified at	Usual Residence of Decedent  10a. Stete  10b. County  MD.  BALTIMORE  10c. of Decedent  10c. of Decede	City, Town or Location BALTIMORE	10d. Inside City Limits 1 □ Yes 2XX10o
	23a or 2	10e. Street end Number 603 WINDWOOD ROAD	10f. Zip Code 21212	10g. Citizen of Whet Country? U. S. A.
020	urs after des	11. Marital Status  1 Never Married XX Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  14. Yes 2 No fight 7 st, Give Year or Dates: WW	If Yes, specify Cuban, Mexican, Puert	Specify: WHITE
Baltimore, Maryland 21215-0020		15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)  2	16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  VICE PRESIDENCE	king CATHELL BROTHERS STEEL COMPANY
/land	d off	17. Fethers Name (First, Middle, Last)	18. Mother's Nan ROS	ne (First, Middle, Maiden Sumame) E NORWOOD
, Mary	tra tra	19a. informant's Name/Relationship (Type, Print) GLORIA E. LESSNER (WIFE)		rel Route Number, City or Town, State, Zip Code) LTIMORE, MARYLAND, 21212
imore	nit. Pages i en entment of Heal ortant: If Item 2 'Injury or other	1 Rurial 2 Cremetion 3 Removal from State	o. Place of Disposition (Name of commetery, cremetory of other place) ORRAINE PARK CEMETERY 03	Date 20c. Location - City or Town, State -11-2004 WOODLAWN, MARYLAND
Ball	permit. Pag Depertment Important: I any Injury o	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility RUCK TOWSON FUNERAL	1050 YORK ROAD L HOME,INC. TOWSON, MD. 21204
	Physician /Medical Examiner	23a. Part1. Enter the diseese, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to	eath. Do not enter the mode of dying, such as cardiac  All James Dimension (1):	Onset and Death
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physicien end page 2 should be deteched for use as the buniel-trensit commissed by Dhysician Madinal Evanings.	Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):	
Box	death d for u	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
s, P.O.	s that the ined by the e deteche	Sepsis Linal failur		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours effer death.  To the Funeral Director: After this certificate hes been signed by the attendicompletely filled in by the funeral director, page 2 should be deteched for use Madical Certification: To Re Commisted by Dhyseldian.			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
E E	Cete h			1 Ves 2 VINO 1 Ves 2 NO No
ξ	certific irector	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2	Other:	th (Check only one) ome 5  Residence 6 Other (Specify)
ion of	Attending Physician: or death. ector: After this certific by the funeral director,	27. Manner of Deeth 28a. Date of tnjury (Month, Dey Year) 29 Accident investigation		28d. Describe how injury occurred
Divis	To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building).	home, farm, street, factory, office cify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	in 24 hour in 24 hour he Funera pletely fill	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner)	nowledge, deeth occurred at the time, date and place, nation end/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the Hospital or within 24 hours effe To the Funeral Dir. completely filled in Medical Cert	end manner stated.  29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	- 5 - 0	► manna flagmundo, m.	D D54518	3-8-2004
	5	30. Name and address of person who completed cause of death (In MACIHA C. MAUMINDO, MD 540)	em 23e) (Type, Print) Ol WCM ROWM BIVA BALHI	Ma 1102/237
	State			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 **Physician** LANCASTER DOLORES ANN 11:00 A.M - 04 - 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROAD TOWSON BALTIMORE 1408 AUTUMN LEAF If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M XX F 72 539-30-1676 Vrs 09-03-1931 WYOMING Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other treumatic event. I've Medical Examiner must be notified at TOWSON MD. BALTIMORE 1 Yes 2/0/No Director the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ROAD 21286 U.S.A. 1408 AUTUMN LEAF or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes 2XXVIIII 1 Never Married AMarried Baltimore, Maryland 21215-0036 WHITE Specify Š 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene. 7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) YEARS OWN HOME HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN ANDREW WALSH RACHEL ROSE TROSKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If Item 27 Is ury or other treus (HUSBAND) 1408 AUTUMN LEAF ROAD, TOWSON, MARYLAND, 21286 ROBERT G. LANCASTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or 03-09-2004 TIMONIUM, MARYLAND, 21093 DULANEY VALLEY M.G. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 R. X. Kul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UTERINE CARCINOMA Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasted or not that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit. and Due to (or as a consequence of) use as the burial-P.O. Box 68760 the attending physicien Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records. PNEUMONIX PIRATION 2 🗹 No 3 Probably 1 □ Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Ves 2 No certificate 1□ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ဥ 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/04 1126637 noleted cause of death (Item 23 (Type, Print) 30. Name and address of person BARRY JOSEPMS M.D.,7600 OSLER DRIVE, TOWSON, 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 1 0 2004

		_	For State Registrar	State of Maryla		artment of H		ental Hygier	2001.	07258
	Physicia /Medic		1. Decedent's Name (First) Middle, Last)  **No Color   Color	PH L	YONS	JR.		2. Date of Death Month	3 2004	3. Time of Death 11:43A M
	Examin	er	4e. Fecility Name (If not institution, give s 600D SAM AX	LITAN HOSP	Hm	BA	TIMPLE		4c. County of Deeth	
	Funeral Director		5. Social Security Number 213-78-2918  Usuel Residence of Decedent	M 2□ F 7. Age (In)	Yrs. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, ye.	59 M	place (State or Foreign intry)
	death with the Maryland me 23s or 28s-f ahow critist be notified at	ctor	10a. State 10b. County	10c.	City, Town or Lo	MUZE				10d. Inside City Limits 1 Yes 2 □ No
	th with the 23s or 28 and be not	Funeral Director	10e. Street and Number 4234 FACKIR	K ROAD		1	21239		Citizen of What Cou	
920	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mantal Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other transite avent, the Medical Existing Institutional in	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I Pes 2 No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: BL	
1215-0036	within 72 ho ene. than *natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired SUPER V	during most of workit d)_		. Kind of Business/Ir SC++00	,
Maryland 21	ould be filed within Mental Hygiene. arkad other than atic avent, tra Me	To Be Co	17. Father's Name (First, Middle, Last)  KUDOLPH ->	IONS SR		30702	18. Mother's Name	(First, Middle, Maid		
, Mary	and 2 should be alth and Mental 27 Is marked er traumatic av		19a Informant's Name/Relationship (Ty	S/SISTER	19b. Mailin 4805	- 4 4 4	and Number of Rura	Route Number, Cit		p Code) 2/2/5
Baltimore	it. Page rtment o rtent: If njury or		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	emoval from State	b. Place of Dispo cemetery, cren REEN MO	sition (Name of natory or other place)  NOT CEFA  Name and Address	MIRRY 3.4	·04 BA		- MARY LAND
B	Derm Depa Impo		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	eations that caused the d	Seath. Do not ent	151 BAUTI er the mode of dyin			E BACTIMON	26. Mp 21229 Approximate Interval Between
68760,	Physician and /Medical Examiner stee penual-fransit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conductor of the conductor)  Due to (or as a conductor)  Due to (or as a conductor)	sequence of):	2y E CARD	EMBOL 10 Myc	YSM DPATH	Y	Onset and Death
P.O. Box 6	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the together.	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etel death 3	Ectopic pregnancy Other (specify)	у		23d. Date of delive Month	very Day Year
	uires that the signed by Id be detac		Part II. Other significant conditions con	itributing to death but not	resulting in the un	nderlying cause giv	ven in Part I.		co use contribute to	the cause of death?
Recor	he law requir e has been si age 2 should l	Completed	- DE	EP VEN	OUS T	HROM	BOSIS	24a. Was an autopsy performed	l?   death?	copsy findings available ompletion of cause of
/ital		Be	25. Was case referred to medical exampler?	locnital:	1	211/	26. Place of Death	(Check only one)		
of	g Physical directions of the direction of the directions of the directions of the directions of the directions of the directions of the directions of the direction of th	n: To	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yee	2 ER/Outpatren 28b. Time of Injury		ner: 4 ☐ Nursing Hor ry at	me 5 Residence 28d. Describe how in		ify)
Division of Vital Records,	al or Attending Physician: after death. I Director: After this certifical d in by the funeral director.	Certification:	1 Whatural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, str	M 1 🗆	Yes 2 □No	28f. Location (Street City or Town, St	t and Number or Rui tate)	ral Route Number,
	To the Hospital or Atterwithin 24 hours after de To the Funerel Directo completely filled in by the	Medical C		sicien: To the best of my ner: On the basis of exar and manner stated.						
	7	Me	29b. Signature and title of certifier	edou i	75	29c. Licens	2732		Date signed (Month)	4
	10		30. Name and address of person who co	mpleted cause of death	A .	Print) FAIR	ZMOUNT	AVE. B	ACTO DI	21286
	Sta Regist		31. Date filed (Months Pay Year) 0 2	32. Registrar's S	ignature &	1 .				

	•	1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	rtificate of Dea		ental Hygi Re	ene g. No. 20	04	0725
		Decedent's Name (First, Middle, I	Last)				2. Date of Death	1		3. Time of Death
Physicia		Mary Eliza	beth Hartman	n Latime	er	l I	Month Iarch		Year 004	4:15 P
/Medica		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or Loca	ition of Death		4c. County o	f Death	
amme	-	Maplewood Park 1	Place Assiste	ed Living	Bethe	esda		Monts	20mei	rv
eral			Sex 7. Age (	In yrs. last birthday)	If Under 1 Year   If U		B. Date of Birth (Month, Day,			lace (State or Fore
or		578-01-1714	1□M 2-F	91 Yrs.	Months Days Tie	1	lov. 7,	1912	Iow	
		Usual Residence of Decedent								ad India On Lin
once.		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10	0d. Inside City Lim 1 ☐ Yes 25 1
	cto	Maryland Montgo	mery	Bethes	da					
	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Coun	try?
		9707 Old Georget	own Road, #1		20814			United		
	Funeral	11. Marital Status	12. Was Decedent Even Armed Forces?	er in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto P	ify Yes or No- ican, etc.)		- Americ , White, t	an Indian, etc.
	F	1 Never Married 2 Married	If Yes, Give		1 ☐ Yes 2 ☑ No Sp	ecity:		Specify:	Whi	te
	d by	3 XWidowed 4 □ Divorced	Year or Dates:							
	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of workin	g   ¹	6b. Kind of Bus	siness/inc	lustry
	Id III	Elementary/Secondary (0-12)	College (1-4or 5+)	ma.						
		17. Father's Name (First, Middle, La	2		Homemaker	Mother's Name	(First, Middle, M		Home	<u> </u>
	Be				1			aloen Jumame	"	
1	70	Harry Hartmann				Helen Sı		Oil as Taura (	Danas Vin	Cardal
1		19a. Informant's Name/Relationship	,		ing Address (Street and N Tucker Lane			_		C00e)
1		Mary Lane Merym	an / in-law					Oc. Location - 0		um Stato
		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 □Removal from State		osition (Name of ornatory or other place)	March	11,			
		*4 □ Donation 5 □ Other (Spe		Cremator	gomery lum, Inc.	2004		ethesda		
		21. Signature of Funeral Service Li	censee	2: P.	2. Name and Address of ethesda-Cheve ethesda, Mar	Facility Robe	rt A. P	umphrey	Fun	eral Home
		LATOS	The same of	1356 B	ethesda, Mar	yland 2	0814-35	61 WI	SCOIL	SIN AVEN
an al er		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aM		Infarction		respiratory arre	st,		Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to or as a r	consequence of						
7.0	Ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
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	ysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon		Day Year
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ORIGINAL

			1 - For State Registrar	State of Maryla	•	artment tificate			nd M	F	Reg. No.	004	
	Physici /Medio Examin	al	Steven Mackay     Steven Mackay     Saint Joseph	Moodie a street and number)	iter	4b. City, T	Fown, or l	Location of	Death WS0	2. Date of Deg Month MARC	Day	Yeer 2004 unty of Death Balt	
	Funeral Director		5. Social Security Number 6. S		. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day		9. Birth Cot	nplace (State or Foreign intry) cotland
	ne Maryland 8a-f ahow Alffied at	Director	10a. State 10b. County  MD Baltimo		ity, Town or Lo Towson								10d. Inside City Limits 1 ☐ Yes 2X No
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28e-f ahow any injury or other traumatic avent, I'm Medical Evarities must be multified at ance.	Completed by Funeral Dire	10e. Street and Number  205 East Joppa  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest grave)  Elementary/Secondary (0-12)	12. Was Decedent Ever in In Armed Forces?  1 (XYes 2 No 194) If Yes, Give Year or Dates: 194	16a. Deced (Give	1 ☐ Yes 2 dent's Usual kind of word DO NOT use	21 28 ent of His fy Cuban No i Occupat k done du e retired)	panic Orig , Mexican, Specify: tion uring most		cify Yes or No-	Unit	of What Cou ed Sta Race - Amer Black, White ecity: of Business/I	ates ican Indian, i, etc. White
Maryland 21	ould be filed wil Mental Hygien arked other th atic avent, ILe	To Be Con	17. Father's Name (First, Middle, Last) George Mood		Vi	ce Pr		18. Mother	's Name	(First, Middle,	Maiden Sur		ompany
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Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Service ☐	DL DL		Jalley Name and	/ Men	n. Gro	ins. Rud	1/2004 ck Tows son, Ma	on Fur	neral	Maryland Home, Inc.
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,092	icate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse									
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Δ.	n requires that the de been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying ca	iuse giver	n in Part I.		23e. Did to			the cause of death?
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Division of Vital	ding Phy n. After this funeral d	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Notural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not b		ER/Outpatien 28b. Time of Injury		Other Sc. Injury a Work?	4 □ Nur	sing Hom 2	(Check only or e 5 Resid 8d. Describe h	ence 6 🗆		ify)
DIVIS	P P P	ai Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)			date and		City or Tow	n, State)		al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	and manner stated.	ation and/or inv	estigation,	License	nion, death	occurre	d at the time, o	date and plac	oned (Month)	to the cause(s)
9	2th Sta		30. Name and address of person who are filed (Month, Day, Year)	32. Registrar's Sign	M1 DEI	Print)	RIV	Е, Т	DWSI	ON. MAF	YLANI	D 212	Ø4

	State of Maryland / Dep	partment of Health and Menta ertificate of Death	Hygiene 2004 07261
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/Medical Examiner	4e Fecility Neme (If not institution, give street end number)  BALTIMORE VA MEDICAL (	46. City, Town, or Location of BALTINIOR	Death 4c. County of Death
Funeral Director	108-44-0083 XXM 2□ F 48 Yrs.		oth, Dey, Year) Country)
aryland show	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or	Location	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
free death with the Mar free must be notified free must be notified Funeral Director	MARYLAND HARFORD CO ABE  10e. Street end Number  734 CUSTIS ST	10f. Zip Code	10g. Citizen of What Country? U.S.A.
s 1 and 2 should be filed within 72 hours efter death with the Maryland of Heelih and Mental Hygiens.  If Heelih and Mental Hygiens.  other traumatic event, the Medical Examiner must be nothing at 15 mercent from the Medical Examiner must be nothing at 17 be Be Completed by Funeral Director	11. Marital Status  1 Never Married 20XMarried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U.S. Armed Forces?  1XWes 2 No If Yes, Give Year or Dates: 80/94	3. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	
ed within 72 hour ygiene.  The Madceller  Completed b		cedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
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permit. Depermitingoria	21. Signature of Funeral Service Licensee	22. Name and Address of Facility IM C BROWN COMMUNITY FU	NERAL HOME-HARFORD, P.A. D, ABERDEEN, MARYLAND 2100
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i y	HEPATITIS B/C, HYPERTE	ENSION	. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ilan: The artificete octor, pag	DIABETES TYPE 2 25. Was case referred to medical	26. Place of Death (Check	only one)
Physic this or rel dire	examiner?  1 Yes 25 No Hospital: 1 Inpatient 2 EP/Outpati  27. Manner of Death 1 Natural 5 Pending (Month, Dey Year) 2 Accident investigation	of 28c. Injury at 28d. Des	Residence 6 □Other (Specify) cribe how injury occurred
To the Hospital or Attending P within 24 hours effer death or Or the Funeral Director: After completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	City	ation (Street and Number or Rurel Route Number, or Town, State)
the Hospitin 24 hours find 24 hours pletely fill pletely fill ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  Medical Examiner: On the basis of examination end/or end manner steted.	investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
within To the Com	29b. Signature and title of certifier  Muchael Dennet De.	29c. License number	29d. Date signed (Month, Dey, Yeer)
10	30. Name end eddress of person who completed cause of death (Item 23e) (Type	e, Print)	
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signeture	IUH. GREENE ST.	DALLIMORE MD 21301

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygien 2014 07262 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Alvie Warren Miller March 9, 12:15 P M 2004 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 107 W. Cherry Hill Road Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 79 218-14-8696 Yrs. 1924Louisville, MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Reisterstown 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 W. Cherry Hill Road 21136 USA or Itams 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 No White WW II Specify: Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager C & P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be item 27 is marked o George Russell Miller Ella Dell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Miller Wife 107 W. Cherry Hill Road, Reisterstown, MD 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If its eny injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremations, Inc. 03/10/2004 Hampstead, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME ans Reisterstown, MD Part 1. Enter the disease; of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease: of Approximate Interval Between Onset and Death Im hediate Cause (Final dist ase or condition Physician uno HDenocaicinma /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. TYAS 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by of Vital Records, 3 ☐ Probably 4 ☐ Unknown Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 22 No No 1 Yes 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes ZINO 1 Inpatient Certification: To 5. Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Division 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 ☐ Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 Homicide To the Hospital filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one 29b. Signature and title 29d. Date signed (Month, Dey, Year) DOOY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) imonium, Torte 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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Physician   Approximate   Informediate Cause (Final resulting in conditions; and the property of the propert	a	mit. Sorta / inju	21. Signature of Funeral Service	Ocensee		22. Name and Addre	ss of Facility		/D +1 1.	a a	т
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Physician Medical Examinor  The property of th			23a, Part 1, Enter the disease, o								
Medical Examiner  The property of the property	eno,	Navaiaian	shock, or heart failure. List	t only one cause on each line.		,	•			Interval E	Between
Section   Sect			Immediate Cause (Final		_						
Due to (or as a consequence of):  Atrial Fibrillation  Due to (or as a consequence of):  Atrial Fibrillation  Due to (or as a consequence of):  Hypertension  Cause (Disease or highly tainfailed events in resulting in death) Last  Part II. Other significant conditions, and the conditions of the cause of death?  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Colon Cancer  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Colon Cancer  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Colon Cancer  24a. Was an autopsy performed?  24b. Were autopsy indings available prior to code death?  Colon Cancer  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death   (Check only one)  28a. Detect of Injury at work?  1   Yes 2   No    27. Manner of Death   (Check only one)  28a. Detect of Injury 2   (Month, Dey Year)  28b. Direct of Death (Check only one)  27b. Matural injury occurred investigation in the purpose of prior of the cause of death of injury at work?  29c. Cartiller   Security occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and manner as stated.  29c. Cartiller   Could not be cause(s) and mann			disease or condition	aAspirati	on Pne	umonia					
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Renal Fallure    A		ni isi		b							
Renal Fallure    A		and and II-tra	Sequentially list conditions, if any, leading to immediate	Due to	(or es a cons	sequence of):				i	
Renal Fallure    A	09	bee ician buris	cause. Enter Underlying Cause (Disease or injury	c. Hyperten	sion					İ	
Renal Fallure    A	8	cate phys the	resulting in death) Last	Due to	(or as a cons	equence of):				İ	
24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  25c. Place of Death (Check only one)  25c.	×	ding		Renal Fa	ilure					<u> </u>	
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24a. Was an autopsy performed?  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  25c. Place of Death (Check only one)  25c.	<u>.                                    </u>	d by detac						1 🗆	Yes 2™ No	3 Probably 4	Unknown
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Natural 28d. Describe how injury occurred  28d. Descr	orc or	equii						24a. Was	s an autopsy ormed?	available prid	or to
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29a. Certifier (Check on one) 2 Morical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check on one) 2 Morical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signatule and title of certifier 29c. License number D59284 March 3, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u>a</u>	tiffica tor, s	25. Was case referred to medica	ıl			26. Place of I	Death (Check only	one)		
29a. Certifier (Check on 20 Morical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signatule and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  31. Date filed (Month, Day, Year)  32. Registrar's Signature	> :	S Cel		Hospital: 1 X Inpatient 2	☐ ER/Outpati	ient 3□ DOA Oth	ner: 4 🗆 Nursin	a Home 5 ☐ Res	idence 6 ⊡Oth	er (Specify)	
29a. Certifier (Check on 20 Morical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signatule and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	a Phy eral eral				of 28c. Injur					
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D59284 March 3, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	-	spitu hours nere y fille	29a. Certifier	ng Physician: To the best of my k	nowledge, dea	ath occurred at the tir	ne, date and pla	ace, and due to the	cause(s) and ma	nner as stated.	
D59284 March 3, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	:	HC Fu	(Check on 2 Medical one)		nation and/or	investigation, in my o	pinion, death o	ccurred at the time	, date and place, a	and due to the caus	e(s)
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Shahid Shamim, M.D. 1299 Lamberton Drive, Silver Spring, Maryland 20902  State 31 Date filed (Month, Day, Year) 32 Registrar's Signature		na?	30 Name and address of parson							0 18th - 1. J	
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WITH I COUT IN THE STATE OF THE		Registrar		1		Source	/				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 L 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev Physician Ritchie В. 3, Mathews 2004 March 10:47 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1 X M 2□ F Months 95 September 30, 1908 Washington, D.C Director 579-34-3181 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumetic event, the Medical Examiner must be notified at 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 5702 Anniston Road 20817 Funeral United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 X Widowed 4 Divorced Yeer or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Murphy Richard Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth M. Hecker/Daughter 8216 Lancaster Drive, Mentor, Ohio 44060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 7,2004 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Par1. Egyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or liceart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical Respiratory Failure 3 Days Examiner Due to (or as e consequence of): Physician/Medical Examiner Chronic Obstructive Lung Disease Years Attanding Physician: The law requires that the death certificate be exacuted use es the buriel-trens Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or es e consequence of) of Vital Records, P.O. Box 68760, signed by the attending physician I be deteched for use es the bune Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dementia, Malnourished edical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? page 2 should 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury Division 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation heral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 6 To the Hospital within 24 hours or To the Funeral I completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) au D19609 March 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, #202, Gaithersburg, Maryland 20878 Raman Tuli, M.D.

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

MAR 1

0 2004

32. Registrar's Signature,

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			nd Me		giene Reg. No	0001	072	267
-	Physic /Medi	cal	1. Decedent's Name (First, Middle, Las  JANARD HAN  4a. Fecility Name (If not institution, give	VAIDU		4. 65. 9	*			Date of Dea Month MARC	h Day	7,2004		of Death
	Examir Funeral	ner	Shady Grove Adven 5. Social Security Number 6. Se	tist Hospita	a 1 yrs. last birthday)	Rocky	vill 1 Year	If Under 2		. Date of Birth (Month, Day	Me	County of Deet Ontgome: 9. Birt	ry	or Foreign
# . - js	Director		578-60-7595  Usual Residence of Decedent  10a. State 10b. County		8 Yrs.		Days	Hours		(Month, Day [an. 8,				
	the Maryla 28a-f ehor	Director	Virginia Fairfax  10e. Street and Number		airfax	10f. Zip (	Code				IOa Citi	izen of What Co		ity Limits 2 No
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow other traumatic event, Ite Medical Examinational be notified at	Funeral	5411 Gov. Yeard1ey  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XNo		2203 Was Decede If Yes, specif	32 ent of His rfy Cubar		in? (Specif Puerto Ric		nite	ed State  14. Race - Ame Black, White	es rican Indian,	
15-0036	n 72 hours a "naturel", c	leted by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu (Specify only highest grade)	If Yes, Give Year or Dates: ucation de completed)	16a. Dece	1 ☐ Yes 2  dent's Usual kind of work DO NOT use	l Occupa	urina most a	of working		16b. Ki	Specify: As i		ian ———
nd 2121	2 should be filed within and Mental Hygiene. Is marked other than " aumatic event, the Me	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5+		ician			's Name (F	First, Middle, I		ernal Me	dicine	
Maryland	2 should by and Ments is marked raumatice	101	Janardhan Naidu  19a. Informant's Name/Relationship (T)	ype, Print)					or Rural A	loute Number		r Town, State, Z		
imore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once.		Dennis Waller/Son  20a. Method of Disposition  1 □ Burial 2 【Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Removal from State	b. Place of Dispo cemetery, crer fontgome: remator:	sition (Name natory or oth LY ium . I . Name and	e of her place [nc .   Address	) Ma	arch 2004 Rober	9, ct A. I	20c. Lo Beth Pump	k, VA 22 cation - City or I nesda, M hrey Fu 57 Wisco	own, State larylan neral	Home/
	nysician /Medical Examiner		23a. Pert1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the one cause on each line.  a. HR A A A  Due to (or as a con	eath. Do not entread to the sequence of):	Ry f	of dying	such as ca	ardiac or re	ospiratory arre	est,		Approximat Interval Bet Onset and I	e ween
8760,	ate be executed  nysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con:  Due to (or as a con:	sequanes of).	NAI	Di	SCAS	5 E				YEAR!	2
.O. Box 68	the death certifications the attending place as the control of the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	33c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etel death 3 [	Ectopic preg Other (spec					2	3d. Date of deliv		/ear
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the ur	derlying cau	use giver	in Part I.			acco us	se contribute to	he cause of d	_
E .	The ate h page	Completed							_	24a. Was ar autopsy perform 1 Yes 2	red?	24b. Were auto prior to co death? 1 \( \sum \text{Yes} \)	impletion of ca	available ause of
o i	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Fig. 1  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	lospital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year	PVOutpatient 28b. Time of Injury	P4400	Other c. Injury a Work?	4 □ Nursi	ing Home 28d.	heck only one 5 ☐ Reside Describe ho	nce 6	Other (Special occurred	( <b>y</b> )	
=	n ji te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecify)					City or Town,	, State)	Number or Run		per,
;	Nother Hospitel within 24 hours a To the Funerel C completely filled i	Medical	29a. Certifier (Check only one)  1	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, death ination and/or inv	estigation, in	п ту оріг	nion, death	olace, and occurred a	it the time, da	te and p	olace, and due to	o the cause(s)	
,	2 3 4 8		30. Name and address of person who co	9000	D .	D	License r			29		signed (Month,	Day, Year)	
	Sta Registr	te	Aaron snyder, M.D. 31. Date filed (Month, Day, Year) MAR 1 0 2004		1 Center			lockvi	11e,	Maryla	and	20850		

			For State	State of Ma	aryland /		rtment of H			ental Hy		200	1.	070	(0
			Registrar  1. Decedent's Name (First, Middle, La	st)		061	incate of t	Joann		2. Date of De	Reg. No.	200	U	3. Time of De	ath U
	Physicia	an	1	ALE						Month	Day	200	1	1815	М
Į.	/Medic Examin		4a. Fecility Name (If not institution, give				4b. City, Town, or	Location	of Death	-/	4c.	County of Di	ath	1010	
H	L.Xdiffiii		UNIVERSITUOFA	LARYLAND	MED	ILEL	CENTER	BAG	TTHE	ORE					
	Funeral		5. Social Security Number 6.5	Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D.	rth ay, Year)	9. 8	Sirthpla Countr	ce (State or Fe	oreign
Е	Director		219-12-6074	1XM 2□F	79	Yrs.	Michinia Days					24		ÍD	
	pue w	}	Usual Residence of Decedent  10a, State 10b, County		10c. City, T	own or Lo	cation						100	d. Inside City L	Limits
	Aaryle Febo	٥	MD NA		Balt									1 XYes 2	□ No
	the 128a-	Director	10e. Street and Number		Dare	11101	10f. Zip Code				10g. Citiz	en of What	Countr	y?	
	3a or		2812 Baker Str	eet			212	16			1	J.S.A			
	ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V	Vas Decedent of H	ispanic Ori	igin? (Spec	cify Yes or N		4. Race - A Black, W	merica		
9	or its		1 Never Married 2 Married	1 Yes 2 N	No		☐ Yes 2 X No	Specify:		ncan, etc.)		Specify:		ack	
5-003	iral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				ороспу.							
2	be filed within 72 hours after deeth with the Marylend Ital Hygiene. Id other than "natural", or Itams 23s or 28s-f ehow avent, I'ns Medical Exor IInst Lunst be notified at	Completed	15. Decedent's E (Specify only highest gr		1	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during mos	t of workin	g	16b. Kir	d of Busine	ss/Indu	stry	
121	within ne.	m m	Elementary/Secondary (0-12)	College (1-4or 5	i+)	me. L	Sortor	7			U.S	Pos	ta	l Serv	vice
N	filed y	ပိ	17. Father's Name (First, Middle, Las.				501001	18. Mothe	er's Name	(First, Middle			-		
an	b d la b	o Be	Samuel Neale	,				Henr	riett	a Cui	ctis				
Maryland 2	is 1 and 2 should of Health and Men item 27 is marks other traumatic	၉	19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailin	g Address (Street					Town, State	a, Zip C	Code)	
	and 2 salth ar		Rita P. Neale-V	Jife		2812	Baker	Stre	eet,	Balt	imor	e Md	2	1216	
<u>6</u>	s 1 au f Hea item othe		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place			ate		ation - City	or Tow	n, State	100
Ē			XIXBurial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci				e Nat'l	·	3/8/6	)4	Bal	imor	e,	Mđ	
altimore,	permit. Pege Department Important: If eny injury or once.		21. Signature of Juneral Service Lice	hygeo/ /			Name and Address	100000							
m	90E 9		C)ala!	1 (arch		43	00 Waba	sh A	ve,	Balt:	imor	e Md	2.	1215	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	polications that caused one cause on each lin	the death. (	Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory a	arrest,			Approximate nterval Between	en
	Physician		Immediate Cause (Final disease or condition	GFP	515								1	Onset and Dea	45
я	/Medical		resulting in death)	Due to (or as	a consequen	ice of):							1		1
	Examiner		Sequentially list conditions.	b											
	pe is	Examiner	Sequentially list conditions, if any, leading to intrinsicially cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ice of):									
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ice of):							+		
8760,	cate be executed by sicien and the burial-transit	E I		220 10 (21 22											
387	phys the	dlcal		_ d											
9 X	seath certifica attending ph d for use as the	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	,					2	3d. Date of	deliven	,	
Box	atter after	ciar	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)					Month		ay Yea	ar
Р. О.	that the de ned by the a detached f	Physici	9 Unknown	9□ Unknown											
	The law requires that the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the u	nderlying cause give	en in Part i	l.	23e. Did	tobacco us	e contribute	to the	cause of deal	th?
ğ	w requires ( been signe should be	pa	congestiv	c hear	+ -C	2110	ie			10	Yes 2	(No 3□	Proba	bly 4 □Unk	nown
000	law re	plet	B ceil win	phomo	a					24a. Was		24b. Were	autop	sy findings ava	ailable
Division of Vital Records,	The lav	Completed	RCNAT E	ALLUVE							ormed?	death			30 01
ita		Bec	25. Was case referred to medical					26. Place	e of Death	(Check only	/				
<b>&gt;</b>	Physician: this certificated ral director, i	10	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatie	ent 2□ER	VOutpatien	t 3□ DOA Oth	er: 4□Ni	ursing Hon	ne 5∐Res	idence 6	□Other (S	pecity)	10	
0	ng Pt fter th		27. Manner of leath  1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury	28c. Injun World	y at k?	2	8d. Describe	how injury	occurred			
Sio	Attending or death.	catle	2 Accident investigation				M 1 🗆	Yes 2□							
Ξ̈́	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At home c. (Specify)	e, farm, str	eet, factory, office		2		(Street and wn, State)	Number or	Rura!	Route Number	r,
	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		20-0-15-	husiaise T. C.	-6									and .	
	Hosp 24 hol Fune Fune	edical		hysician: To the best miner: On the basis o	f examination										
	To the Hospitel within 24 hours of To the Funeral completely filled	Med	29b. Signature and title of certifier	and manner sta			29c. Licens	e number			29d. Date	signed (Mo	onth, D	ay, Year)	
	F 3 F 8		Marile	, NID			AU4170	6435	A-153	359		-			
-	140		30. Na and address of person who		leath (Item 2	3a) (Tvna				,	_			•	
	5			, AUILES			SITY OF	MA	RILL	AND A	UID	CA-1	AF	UTTER	
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signatur		101	1.0	-40					166	
	Regist		MAND 1 0 20	04	11	Bon	ALL								

		•	For State Registrar	State of	of Marylan		artment rtificate			Mental Hy	giene Reg. N2	) կ	072	69
	busisis		1. Decedent's Name (First, Middle	Last)		_				2. Date of D	aath Day	Year	3. Time of	Death
	hysicia /Medica	al -		helps			1			money	1 4 2	DO 4	10:4	JFT.M.
	xamine	er	4a. Fecility Name (If not institution, North Arundel H	-	ımber)				Location of Dear	ħ	Anne	y of Death Arund		
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)			If Under 24 Hrs	8. Date of B				or Foreign
	neral ector		220-16-4315	1□M 2∰F	78	Yrs.	Months	Days	Hours Min	Dec. 2	rth ay, Year) 25, 1925	Maj	place (State of intry) ryland	
P			Usual Residence of Decedent		100 0	ty, Town or Lo	nonting						10d. Inside C	ity Limits
arylar	e how	2	10a. State 10b. County											2 🔼 No
the M	28a-1	ecto	Maryland Ann  10e. Street and Number	e Arundel	L	Severn	10f. Zip C	Code			10g. Citizen of	What Cou	intry?	
with	9 9	ā	8085 Telegraph	Road				2114	4		Unit	ed St	tates	
death	el', or llems 23e or 28e-f ehow Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U	I.S. 13.	Was Decede	nt of Hi	spanic Origin? (	Specify Yes or N to Rican, etc.)	o- 14. Ra Bla	ce - Ameri	ican Indian, , etc.	
9 atle	o lie	y Fu	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, G	2 ፟M No ive		1 ☐ Yes 21				Spec	ity: W1	hite	
HETAS 1215-0036 within 72 hours after death with the Maryland ene.	at Ex	Completed by	3 Widowed 4 Divorced	Year or I	Dates:	16a. Dece	dent's Usual	Occupa	ntion		18b. Kind of	Business/Ir	ndustry	
15. 27	Medic	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed,	) (1-4or 5+)	(Give	kind of work DO NOT use	done d	luring most of wo	rking				
d 212	The state	mo:	10	College	(1-401 5+)	Но	omemake	er				Home		
		Be (	17. Father's Name (First, Middle,	_ast)						me <i>(First, Middl</i> ane Duri		me)		
Van blud	20	၉	Jasper Phelps	in (Time Oriet)		10b Maili	na Addross /	(Stroot a		ural Route Num		State 7	in Code)	
Mary Mary Mary Mary Mary Mary Mary Mary	7 ie mar traumat		19a. Informant's Name/Relationsl Norman E. Phe		chand		Telegi				, MD 211		,	
62 00 20	Item 2 other		20a. Method of Disposition		20b. I	Place of Disponentery, cre-	osition (Name	e of her place	Mar	chate8	20c. Location		own, Stete	
mor Pages	nt: If I		Burial 2 Cremation 4 Donation 5 Other (S)			en Have				4	Glen E	urnie	e, Mary	yland
Ayou Baltimore,	Important: If Ite eny injury or ot once.	- 1	21. Signa ure of Funeral Sirvice	icensee		2:	2. Name and			E	Home D	7	210	61
<b>m</b> & & &	E = 8	111	Meller	W						Funeral y S.E. (		nie,	Maryla	
d <sub>x</sub>			23a. Pert 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deal each line.	th. Do not en	ter the mode	of dying			arrest,		Approximate Interval Bet Onset and	tween Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	- Lity	ugeth	re 1	recort	*	Jarl	ne		-		-
	miner			Due to	(or as a consec	quence or):	~ 1	_						
	C.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence (1)	Levin	7	,					
cuted	sician and burial-transit	Examiner	that initiated events	c. Q	mal	-	Ch-N	usit	ion					
760, 1e be executed	urial-1		resulting in death) Last	Due to	o (or as a consec	dneuce ou:								
- W	physic the b	dlcal		d										
Records, P.O. Box 68 The law requires that the death certifical	attending physician for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn						23d. D	ate of deliv	very	
. BG	d for t	Iclar	in the past 12 months?	4□Preg	birth 2 ☐ Feta gnant at time of t		□Ectopic pre □ Other <i>(spe</i>				N	fonth	Day	Year
P.O.	ed by the detached	hys	9 🗆 Unknown	9□Unk				-				- 27		
S, F	pe pe	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	underlying ca	iuse givi	en in Part I.		tobacco use co	ntnbute to 3 □ Pro		death? ]Unknown
ord	should	Completed	methologic	ESTON	M.	L00-1	The same of the sa				/\			
e aw	has b	mple									opsy formed?	prior to death?	topsy findings completion of c	cause of
2 th	certificate has rector, page 2		25. Was case referred to medica						as Place of Dr	1 ☐ Yes	2 <b>X</b> No	1 □ Yes	2 No	
Vit		To Be	examiner?	Monnitel	Inpatient 2	∃ ER/Outpatie	nt 3□ DO	A Oth	ac.	Home 5 Re		ther (Spec	ify)	
of gPhy	er this		27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time o		3c. Injun	/ at k?	28d. Describe	how injury occi	perni		
Division of Vital Records, to Attending Physician: The law requires taller death.	or: At	Certification;	2 Accident investi	gation			M		Yes 2 □No		(0)	1		-
) iVis	Direct in by t	THE STATE	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	200. Flat	ce of Injury - At I ding, etc. (Spec	home, farm, si	treet, factory,	, office			(Street and Nur own, State)	iber or Hui	rai Houte Nun	noer,
Division of Vital	To the Funeral Director: Atter this certific completely tilled in by the funeral director.		29a. Certifier 1X Certifyin	ng Physicien: To the	he best of my kn	nowledge, dea	th occurred a	at the tin	ne, date and place	e, and due to th	e cause(s) and r	nanner as	stated.	
e Hos	e Fur letely	Medical	(Check only 24 Madicel one)	Examiner: On the	basis of examin inner stated.	ation and/or in	nvestigation,	in my o	pinion, death occ	curred at the time	, date and place	, and due	to the cause(	s)
Toth	To th	M	29b. Signature and title of certifie	r -			29c.	Licens	e number		29d. Date sign	ed (Month	, Day, Year)	3 4
	4		Agitas		MIC	>	د ا	14:	3977		March	4	- 200	4,
	4		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type	, Print)	r N	11 0	'n	11 ~	) I	Dhl	
	Sta	to.	31. Date filed (Month, Day, Year,	32.	Registrar's Sign	autenalla	1	2	John !	mme	11/10	01	701.	
	ાત Registr		MAR 1 0 2004	L'Engles.	1 10	all a second								

V V			1 - For Unpend Item#23a,	State of N 27,28a f,Pe	Maryland / De r ME,G829,3/	partment of 22/04e2 e <i>rtificate o</i>	Health ar	nd Mental Hy	giene 00	4 07270
			Decedent's Name (First, Middle, La.					2. Date of De	ath	3. Time of Death
	Physici		John Timothy Po	rea IV				Month March	06, 2004	1 0248 A M
>	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of		4c. County of	
	E Adrilli		Northwest Regiona	al Hospit	al	Randa	allstowr	1	Balt	imore
ŏ	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthda			Hrs. 8. Date of Birt		Birthplace (State or Foreign Country)
	Director		214-17-1448	□M 2□F	27 Yrs.	Months Day	ys Hours	Min. 8. Date of Bin (Month, Da June	15,76	Baltimore, Md.
)	D		Usual Residence of Decedent							
	rylar		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Ba-1 s	cto	Md. Baltin	ore		Reist	erstown	L		1 ☐ Yes 2 ☐ No
	ii ti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	1
	death with the Maryland ms 23a or 28a-f show fmust be notified at	al	222 Highmeadow F	load			21136		U	JSA
		Funeral	11. Marital Status	<ol> <li>Was Deceder Armed Forces</li> </ol>	nt Ever in U.S. 1	<ol> <li>Was Decedent of If Yes, specify C</li> </ol>	of Hispanic Origin uban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Black	- American Indian, White, etc.
36	or li	by Fu	Never Married 2 Married	1 ☐ Yes 2X☐ If Yes, Give		1 ☐ Yes 2 🛣 N	No Specify:		Specify:	rm .
8	be filed within 72 hours after tal Hygicne. d othe "then "natural", or Ite event, the Medical Evantine.		3 Widowed 4 Divorced	Year or Dates		and a Na Harris Occ			10h 16' - 1 - 1 B	White
15	n 72 na edic	Completed	15. Decedent's Ed (Specify only highest gra		(Gi	cedent's Usual Occ ve kind of work dor DO NOT use ret	ne during most o	of working	16b. Kind of Bus	siness/Industry
12	4 2 2 3 4 1 2 3 3 4 1 3 3 4 3 4 4	m d	Elementary/Secondary (0-12) 12 Grade	College (1-4o	r 5+)	Laborer			Landsc	ane
27	be filed Within 72 houtal Hygishe "nature dother than "nature event, an Modical E.		17. Father's Name (First, Middle, Last)					s Name (First, Middle,		•
Baltimore, Maryland 21215-0036	2 should be for and Mental by and Mental by is marked of raumatic ever	To Be	John T. Pore	a 3rd			Ch	arlotte Wi	neberg	
2	should ind Men ind Men inmarke	F	19a. Informant's Name/Relationship (	ype, Print)	19b. Ma	iling Address (Stre		or Rural Route Numbe		State, Zip Code)
5	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatice		John T. Porea 3rd					d Reister		
ē,	Hea Hea tem	1 3	20a. Method of Disposition		20b. Place of Dis	position (Name of		Date	20c. Location - C	City or Town, Stete
<u>o</u>	permit. Pages 1 Department of H Important: If ite any injury or ot once.		1 ☐ Burial ※☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		θ .	rematory or other p			Therefore Street College	necessaria propare
₽	oit. Partme	1	21. Signature of Funeral Service Licer		Carrol	<ol> <li>Cremating</li> <li>Name and Add</li> </ol>		larch 9.04		itead, Md.
Ba	permit. Departr Importa any inji		Frank O	Same.	Į.		Funeral			erstown Rd.
			23a. Pert1. Enter the disease, or com	olications that cause	ed the death. Do not a					n ,Md.21136
			shock, or heart failure. List only	one cause on each	line.					Interval Between Onset and Death
	Physician /Medical	/	disease or condition resulting in death)	a	ic (Heroin)	THIOXICALIC	X1			
	Examiner			Due to (or a	s a consequence of):					
1/20		e.	Sequentially list conditions,	b. Due to (or a	s a consequence of):					
	betr Insit	m F	Sequentially list conditions, if any, leading to annudate cause. Enter Underlying Cause (Disease or injury							
,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):					
8760,	e be sicia s bur	dical		d						
89		edi								
Box	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy				23d. Date	of delivery
m	death e atte d for	Icia	in the past 12 months?	4 Pregnant		B□Ectopic pregnar B□ Other (s <i>pecify)</i>			Mont	h Day Year
0	t the de by the	hys	9 Unknown	9□ Unknown						
σ,	requires that the been signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
P.	quire n sig uld b	pe pe						1 🗀 Y	′es 2□No 3	B ☐ Probably 4 ☐ Unknown
Vital Records,	law requir as been si 2 should	Completed						24a. Was	an 24b. W	ere autopsy findings available
Re	9 2 9	E O						autop	rmed?   de	or to completion of cause of eath?
ta	(0)	0	25. Was case referred to medical				26 Place O	Death Cleo on o	2 No   1	Yes 2□ No
	Phyaician: this certific ral director.	To B	examiner? 1 XYes 2 □ No	Hospital:	tient 2 <b>XX</b> R/Outpat	ent 3□ DOA	)ther	ing Home 5 ☐ Resid	-107	(Snecify)
of			27. Manner of Death	28a. Date of In (Month, D	jury 28b. Time	of 28c. in	jury at		ow injury occurred	
io	Attending I r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	- 1- 1	lay Year) Injun		lork? □Yes 2🗶No	unknown		
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of I	njury - At home, farm,	street, factory, offic	е	28f. Location (S	Street and Number	or Rural Route Number,
Ö	s after s afte	Sert	4   Homedo	unknown	atc."(Specify)			unknown	rr, State)	
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowledge, de	ath occurred at the	time, date and p	place, and due to the o	cause(s) and man	ner as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exemone)	and manners	or examination and/or stated.	irivestigation, in my	y opinion, death	occurred at the time, o	ate and place, an	a due to the cause(s)
	To the within 2. To the f	Σ	29b. Signature and title of certifier			29c. Lice	nse number	4	29d. Date signed	(Month, Day, Year)
			Mon	e(M)		0.	C.M.E.		March 0	6, 2004
			30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)				
_			J. LAKON WY	E MY			Street,	Baltimore	, Maryla	nd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	sporter	/			
	Registr	ar	300 1 0 2004	Con Con		E				

		1	For State Registrar	State of Maryland	/ Department of Health and M Certificate of Death	lental Hygien Reg. N	e2004	07271
			Decedent's Name (First, Middle, Last)	0		2. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		ROBERT L	- PRIC		March 1	2004	0525 AM
	Examin		4a. Facility Name (If not institution, give st. North West Hospi	er i i	4b. City, Town, or Location of Death	4	Baltima	×e
	C		5. Social Security Number 6. Sex	7. Age (In yrs. las	Randall Stown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birtho	lace (State or Foreign
h	Funeral Director			M 2 F 7	Yrs. Months Days Hours Min.	(Month, Day, Yea)	7 Mar	Eyland
	pur *	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		1	0d. Inside City Limits
	Manyla ( • ho		ms Ballic	MARE	BALTIMORE			1 ☐ Yes 2 ☐ No
	r 28a-	rec	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Cour	ntry?
	23a o	Funeral Director	7708 Wind:	SOR Mill F	a. 21244		USH	
	er dea	nuei	1 . Maritar Status	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> <li>1 MYes 2 □ No</li> </ol>	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	or or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	RYes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	rite.
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow the Mudical Examinar must be motified at	Completed	15. Decedent's Education (Specify only highest grade		16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b.	Kind of Business/Inc	dustry
121	within ene. then	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	Intel DO NOT use retired)	6	SAD Rai	Leggal
d 2	filed Hygie other		17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	en Sumame)	TRECE
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene them 23a or 28a-1 show item 27 is marked other then "naturel", or items 23a or 28a-1 show other treumatic event, it is Medical Exactions must be notified at	To Be	KOSS W. PR	ice.	Rut	h Waru	vick.	
lan	2 should and Men is marks eumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip	
-	1 and Health em 27 ther tr		20a. Method of Disposition	20b. Pla	ce of Disposition (Name of	Date 20c.	Location - City or To	MD 2/152 own, State
nor	0 0 = 5		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	natery, crematory or other place) SFUNZRAL (HAPEL 3-8		REST H	_
Baltimore	그 문문을 .		21. Signature of Funeral Service License		22. Name and Address of Facility	nonium		
ä	Depa Impo eny ii		Kinberly	1. Swistry	FUAND FUNERALCI	HAPEL 23		CRD.
П				ations that caused the death	Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Myocard				2 days
b	Examiner			Due to (or as a conseque	yosatty			lyv
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque				( )
	ecuted and transi	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	U Colon			6 onls
8760,	cate be executed obysician and the buriat-transit	al E		Sensil	mus orj.			6 days
687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	a.					
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant	sc. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of			23d. Date of delive	ery Day Year
.O. E	ne dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	ath 5 Other (specify)			Ju, Tour
<u>α</u>	res that the de signed by the a be detached i			tributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Vital Records,	w requires been sign should be	ed by				1 🗆 Yes	2 No 3 Prob	oably 4 Unknown
900	ne law re has bee ge 2 sho	Completed				24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
<u>=</u>	The cate ha	Com				performed 1 ☐ Yes 2 🔀	?   death?	2 No
Vita	ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	ospital:	Other	th (Check only one)	C Cother (Canal	
of	Phys er this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injury at	28d. Describe how in		<b>y</b> /
ion	ath. or: Afte	atlo	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury Work?  M 1 Yes 2 No			
Division	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, St		al Route Number,
	spital ours a neral C		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, death occurred at the time, date and place	, and due to the cause	(s) and manner as s	tated.
	ne Hoo n 24 h ne Fur	edical	(Check only 2 Medical Examin one)	er: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occu			
	To the vithin To the comp	Σ	29b. Signature and title of certifier	01.46	29c. License number		Date signed (Month,	
			P K Y W	INVIJAC	1 an 150950	M	with 6	, 2004
	15+1		30. Name and address of person who co Nucemeka Aa	mpleted cause of death (Item  7445	Jan D56950 23a) (Type, Print) = Fornace Brand R ure	d. Glen 1	Burnie M	10 21060
	Sta	ate	31. Date filed (Month, Day, Year)	1		1		
	Regist	rar	MAR 1 0 2004	De sever	& Anal.			

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			Please		ack indelible ink.			gible.	
			For State Registrar	State of Maryland	I / Department of He Certificate of D		Reg. No.	004 07272	
	Physici		1. Decedent's Name (First, Middle, Last	DOSECE		2. Date o Month	f Death Day	Year 7:05 p M	_
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or I	Marc_ _ocation of Death		2004 7.03 P.m.	
1	CAUIIII		BERLIN NURS	sing Home	BER	LIN	L	Dorcester	
F	Funeral Director		5. Social Security Number 6. Se 234-24-576	× 7. Age (In yrs. la	st birthday) If Under 1 Year Months Days	Hours Min. 8. Date o	f Birth n, Day, Year) 17-192	9. Birthplace (State or Foreign Country)	
	pug M		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits	-
	Maryl.	tor	MD WORCE	Stor	Berlin			1 ☐ Yes 2 ☐ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow appring yor other traumatic avent, it a Madical Examinar trausible modified at Once.	Funeral Director	10e. Street and Number	Picala	10f. Zip Code	211	10g. Citizen	of What Country?	
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent of His	panic Origin? (Specify Yes o , Mexican, Puerto Rican, etc.	r No- 14.	Race - American Indian, Black, White, etc.	_
036	urs after al', or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 D No	Specify:		pacify: White.	
21215-0036	72 ho	Completed by	15. Decedent's Edi (Specify only highest grad	lication le completed)	16a. Decedent's Usual Occupat (Give kind of work done du		16b. Kind	of Business/Industry	
121	within and then then then then then then then then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	BOOK Kee DA	20	Auf	2650005	
	illed with Hygiene. other ther	Be Co	17 Eather's Name (First, Middle, Last)		DOURNEEP	18. Mother's Name (First, Mi	ddle, Maiden Su	mame)	
/lan	should be nd Mental marked o	To B	Kansom Smi	th		Susie Ho	11		
Maryland	2 sho		1 a. Informant's Name/Relationship (7	rpe, Print)	19b. Mailing Address (Street ar	nd Number or Rural Route N	umber, City or To	own, State, Zip Code)	
	1 and Health am 27 Sther tr		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of	Date	20c. Locat	ion - City or Town, State	-
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 eny injury or other ance.		1/☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	metery, crematory or other place (dens of Fair	th 3-10-20	XI ROS	odalo ms	
alti	permit. Page Department Important: # eny injury o		21. Signature of Funeral Service Ligen:		22. Name and Address	of Facility BALTIN	PORE,	mD 21234	Ī
<u>-</u>	88558		Kimberly 4.	Zawiolky	EVHUSFU			800 HAKTOKDE	K.
В			23a. Part1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	licitions that caused the death.	Do not enter the mode of dying			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons-	7	mers De	ment	en 5 yps	
	Examiner		Constant the first and distant	h					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
_	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of);				_
760,	sician buria	70		d					
189	tificate ig phy as the	ledic		·					
Box	death certificate e attending physi d for use as the l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1□Live birth 2□Fetel of	death 3 Ectopic pregnancy		23d	l. Date of delivery Month Day Year	
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	ath 5 ☐ Other (specify)				
Ω,	iaw requires that the de as been signed by the a 2 should be detached t	by Ph	Part H. Other significant conditions co	ontributing to death but not resul	iting in the underlying cause give	n in Part I. 23e.	Did tobacco use	contribute to the cause of death?	Ī
ecords,	w requires been sign should be		allerwicke	role (ar	deivascul	Veran	1 □ Yes 2 5 🛣	No 3 ☐ Probably 4 ☐ Unknown	
ecc	e law re has be je 2 sho	Completed	Essential	Hyper	fension		autopsy	24b. Were autopsy findings available prior to completion of cause of	
al B	The Sag		Cenemia			1 🗆 Y		death? 1 ☐ Yes 2 🔀 No	
Viital	nding Physician: th. : After this certifica s funeral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 □ DOA Other	26. Place of Death (Check of 4 Mark Nursing Home 5 🗆 I		Other (Specify)	
J Of	ig Phy ter this neral d	h-	27. Manner of Death		28b. Time of linjury Work'		ribe how injury or		Ī
Sior	Attending r death. sctor: After by the fune	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 □ Y	es 2 No			
Division	- 0.5	Certification;	4 Homicide determined	28e. Place of Injury - At horn building, etc. (Specify)	ne, farm, street, factory, office		ion (Street and N r Town, State)	lumber or Rural Route Number,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (			viedge, death occurred at the time on and/or investigation, in my op				
	To the To the To the Comple	Me	29b. Signature and title of certifier	( ) m	29c. License			igned (Month, Day, Year)	_
			Jugario M.	12elland	an DZ	7505	03 -	05-2004	
	3		30. Name and address of person who			CT DV OP C	1100140	W MD SIGNI	
	St	ate	GREGORIO M. B	32. Registrar's Signatu		KKY VK, SA	LISBUK	7,1417 21801	_
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			State of N	naryiand / Depa <i>Cei</i>	artment of r rtificate of			iene .g. No ? () (	۱ ل	0727	3	
	D	1. Decedent's Name (First, Middle	le, Last)				2. Dete of Deet Month	h	Year	3. Time of Dea	th	
П	Physician /Medical	Harriette Rie	lla Quasney	·			March	4 2004	1	4:00 a	m	
	Examiner	4a Facility Neme (If not institution	_	r)		4b. City, Town, or Lo	cation of Deeth	4c. County of	of Deeth			
		Sunbridge Nurs			If Under 1 Year	Elkton If Under 24 Hrs.	O Date of Birth	Cec		· · · · · · ·		
	Funeral Director	5. Social Security Number 216–42–8263	6. Sex 1 □ M 2X F	Age (In yrs. lest birthday) 85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 2	Year) 1918		ace (State or For ry) yland	reign	
	Bud **	Usuel Residence of Decedent  10a. State 10b. County	,	10c. City, Town or Lo	cation				10	d. Inside City Lir	mits	
	the Marylan 28a-f show notified	Maryland Ceci	1	Elkton						1 ☐ Yes 2√	] No	
	iter deeth with the Mar riter must be notified Funeral Director	10e. Street end Number		1	10f. Zip Code		10	0g. Citizen of W	hat Count	ry?		
	th with 23a or	123 Cherry Hi	ll Road		219	921		Unit	ed S	tates		
	items 2	11. Maritel Status	12. Was Deceder Armed Force	nt Ever in U,S. 13. \		lispenic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- America	in Indian,		
Maryiand 21215-0036	urs e	3 Widowed 4 □ Divorced	ried 1 ☐ Yes 2 ☑ If Yes Give	₫ No	1 ☐ Yes 2X No			Specify:	Wha			
5-0	ied within 72 hours ygiene "neturei", hr. the Medical Exa Completed by	15. Deceden	it's Education st grade completed)	16a. Deced	dent's Usual Occup	petion during most of work d)	ing	16b. Kind of Bus	siness/ind	ustry		
2	within and the first of the fir	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retire	d)						
2	iled with hygiene her tha mt, the	10 17. Fether's Neme (First, Middle,	( act)	F	Homemaker	18. Mother's Name	a /First Middle A		m Ho	me		
and	ges 1 and 2 should be filed t of Health and Mental Hyg if Item 27 is marked other or other treumetic event, To Bae C	Molarin Dunklag	Last)						"			
Ž	12 should be and Mental is marked of reumetic every To B.	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mailir	ng Address (Street		Betsy Thompson  er or Rurel Route Number, City or Town, State, Zip Code)					
Z	Ith ar	Janet Perkey		4		11 Road,		-				
<u>6</u>	f Hea f Hea other	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	cal Today		20c. Location - C				
Ę	8 5 4 >	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Glen Have			3/8/04	len Bur	nie.	Marvlar	hr	
Baitimore,	pemit. Pages 1 and Department of Health Important: if Item 27 eny injury or other ti once.	21. Signature of Funeral Service	Licensee		. Name and Addre		bbard Fu					
ш	20 E B 20	1 lenn	1. XUNK			ens Avenu			aryl	and 2122	29	
		23a. Part1. Enter the diseese, or shock, or heart failure. List	complications that caus	ed the deeth. Do not ent- line.	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between	1	
	Physician			Δ					!	Onset and Death		
1	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a			e Infara	clein		7	manav.	2.	
				Due to (or as a conseq		,				/ -		
	executed in and ital-transit		b	Myperten.					u	ne nau	7	
ó	exec an an riai-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events		0 11	sufficie	44.69			1.7	inknav. inknav inkna	. 17	
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	£ 0.6		L			•			-			
Box	th ca tendi or use		d							-		
	the at the a feet	Part II. Other significant condition	ons contributing to death	but not resulting in the ur	nderlying cause giv	en in Part I.	23b. Did to			the cause of de		
P.0.	The law requires that the death card sate has been signed by the attending page 2 should be detached for use Completed by Physician/M	Duenh	agia				1 □ Ye	s 2 No	3 Prob	ably 4 1 Unki	nown	
ds,	sign d be	(0)					24a. Wes ar	eutopsy	24b. We	re autopsy findin	igs	
Ö	been shoul						perform	ned?	COTT	ilable prior to apletion of cause eath?	,	
Re	has has ige 2						1 🗆 Ye	s 212No		Yes 2□ No		
tai	ificate or. pa	25. Was case referred to medica	1			26. Place of Deatl				165 2010	-	
>	hysician: his certifical director	examiner?	Hospital:	itient 2 ER/Outpatien	t 3 DOA Oth		me 5 Reside		(Specify	}		
0	erthis eral c	27. Menner of Deeth	28e. Date of Ir	niury 28b. Time of			28d. Describe ho					
ō	ath. r: Aft re fur	1 Matural 5 ☐ Pendir investi	getion	injury injury		Yes 2□No						
Division of Vital Records,	frer de Merce Directo in by th	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd 200. Plece of t	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Str City or Town		r or Rural	Route Number,		
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com			et of my knowledge, deeth							-	
	the Hu in 24 he Fu plete	one)	end manner	of examination end/or inv stated.							1	
	within To the common	29b. Signeture end title of certifie	<i>y</i>		29c. Licens			Od. Date signed				
	1	P +	Behaler S	ms	200	23322		March	4,0	14		
	1)	30. Name end eddress of person	who completed cause of	deeth (Item 23e) (Type,	Print)	Elpt	n MD =	21921				
	State	31. Dete filed (Month, Dey, Year)	2004 32 Regis	i deeth (Item 23e) (Type,  Nach Strer's Signature	the second							
	Registrar	MIAK I U	C001									

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Oureshi OUMuhmmad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Roseda Le
| Under 1 Year | If Under 24 Hrs. | 8. Date of Birth |
| Under 1 Year | Hours | Min. | 1 2 20 Franklin Square Hospital Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** XXM 2□ F Pakistan N/A 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State il Hygiene, cither than "natural", or items 23a or 28a-1 ehow vent, the Medical Examiner roust be nuffited at 1 ☐ Yes 2 No Director Lahore Pakistan 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Pakistan 215 P Defense Housing Authority by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes ZOXNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Asst. Vice President 12th grade 4 yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental I Muhummad Sharif Oureshi Saeeda Begum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21061 permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau Rubina Goindi-Sister-In-Law 6430 D Centennial Circle, Glen Burnie, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition V☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/13/04 Lahore, Pakistan Lahore Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West hompson 21215 4300 Wabash Ave, Baltimore Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ← ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 No Division of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After t 5 Pending investigation Hospital or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 38363 who completed cause of death (Item 23a) (Type, Print) N. OHAPLES GRASSO MD FRANCES CO 31. Date filed (Month 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

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			1 - State Registrar	State of Man	yland / Depa		lealth and N	¶ental Hygie Reg		07275
*	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last,     Dr. Frederick L     4a. Facility Name (If not institution, give	. Richards	on		r Location of Death	2. Date of Death Month March	Day Year 05, 2004	3. Time of Death 11:55 A <sup>M</sup>
	Funeral Director		Sinai Hospital  5. Social Security Number  6. Security Number  216-38-4638  Usual Residence of Decedent	7. Age (I	n yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry) ngland
	he Maryland 8a-f show citited at	Director	10a. State 10b. County  MD n/a	10	Oc. City, Town or Lo	ore				10d. Inside City Limits 1
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Health and Mental Hygene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Wedical Examinar must be notified at	by Funeral	10e. Street and Number  111 Hamlet Hill  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Road  12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto Specify:		United St  14. Race - Ameri Black, White	ates can Indian,
Maryland 21215-0036	d within 72 hou piene. Ir than "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	ent's Usual Occup kind of work done OO NOT use retired	during most of work d)	ing	b. Kind of Business/Ir	ndustry
ryland ;	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Frederick A. Rich 19a. Informant's Name/Relationship (Ty	nardson		•	18. Mother's Nam Gertru	e (First, Middle, Ma de Tho		a Coda)
	os 1 and 2 s of Health an f item 27 is r r other traus		Virginia G. Richa  20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ P	ardson/wife	3801 20b. Place of Dispos	Canterbu	ry Road #	717 Bal	timore, MI c. Location - City or T	21 21 8 own, State
Baltimore,	permit. Pages Department of I Important; if it any injury or o		*4 Donation 5 Other (Specify)  21. Signarure of Funeral Servicer License			erv. Cor Name and Addre 1050 Yor	ss of Facility Ru		owson, MD Funeral b eryland 21	
\$	Physician /Medical Examiner		23a. Paint. Enter the disease, or compleshook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)		death. Do not ente					Approximate Interval Between Onset and Death
8760,	te be executed ysician and e burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
.O. Box 68	aath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 { 4 ☐ Pregnant at tim 9 ☐ Unknown	∃Fetal death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of deliv Month	ery Day Year
٥.	wrequires that the de been signed by the should be detached	by	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did tobad	co use contribute to t	he cause of death?
Vital Records,	Physician: The law r this certificate has be al director, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy performer	d? death?	opsy findings available impletion of cause of
ם נ	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification is the funeral director, the funeral director, and the funeral director.	Certification: To Bo	avaminar?	1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc.)	- At home, farm, stre	28c. Injur Wor 1 🗆	er: 4 🗆 Nursing Ho	28d. Describe how	st and Number or Rura State Road c	Fixed oba
	the Hospit. hin 24 hours the Funera ni letely fille	Medical C	one) 2 Medical Exami	ner: On the basis of example and manner stated	y knowledge, death	estigation, in my o	pinion, death occurr	ed at the time, date	e(s) and manner as s and place, and due to	taleu. o the cause(s)
)	with	2	29b. Signature and title of certified	impleted cause of the att	Ooligh (Item 23a) (Type 5		O.C.M.E.	- 1	Date signed (Month, arch 06, 20	
	24 Sta	ite	31. Date filed (Month, Day, Year)	N CA - W	(N/111 E		et, Balti	more, Mai	cyland 2120	01

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State of Maryland / Department of Health and Mental Hygiene For State Registrar 004 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Yeer **Physician** MARCH 1251 PM 05 2004 Kicks neary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boutmore & If Under 14 Hrs. pital Union Memoreia 5. Social Security Number 6 Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 € F 246-30-0544 N.C. Director October Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f shov Exercises cust be collified at 1'Yes 2□No Director M.D Ba Himore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3600 U.S.A. 21229 ranklin 51 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify If Yes, Give Year or Dates: Specify: þ Black 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than . Elementary/Secondary (0-12) College (1-4or 5+) 1 Glass Windows alass maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Susan Blunt ၀ Nable Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is WILL'E Sopps
20a. Method of Disposition 3600 Baltimore MD 21229 W. Frankin St 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/04 memorial BATHIMUNE MD 4 Donation 5 Other (Specify) ARbutus 22. Name and Address of Facility BEHS FURERAL Home 21. Signature of Funeral Service Licensee Det 11/29 N. CARUINE St. BAHMUNG MD 21213 aturio Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DOSIS 1 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of ceptifier AT2438946 MARCH 05 2004 30. Name and address of person who completed cause bi deard (Item 23a) (Type, Print) 201 EAST UNIVERSITY PARILWAY BALTINDRE, MARYLAND 21218 MICHELLE FUSELIER 32. Registrar's Signature 31. Date liled (Month, Day, Year) State parker 10000 Registrar MAR 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician OSENBERGER 9:05 PM REDERICK TARC 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner VIEDICALL SAPEAKE STON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 ARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 219.58.659 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic svant, the Madical Examination will be investified at 1 ☐ Yes 2 No MARYLAND HARFORD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 21015 ARBY OURT Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 178 Yes 2 No If Yes, Give Year or Dates: 1969-1975 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be -REDERICK KOSENBERBER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JARBY CT. BEL WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State PARKVILLE PARKWOOD CEMETERY ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility EVANS FUNGRAL MD 2123 RD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure) List only one gause on each line. Approximate Interval Between Onset and Death one cause Immediate Cause (Final disease or condition resulting in death) **Physician** 1cev /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dus to for as a consuguence offit any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and i-transit Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 □ ER/Outpatient 3 □ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After or Attanding 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 MYO TIMANT TWW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 0 2004 Registrar

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State of Maryland / Department of Health and Mental Hygiene 20041 - For State Registrar 07278 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Richardson March 8 2004 2:20a. M Edgar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days **XX**M 2□ F Hours Director 87 249**-**10**-**6869 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1√ Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. Items 23a 21216 3121 Presbury Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter 1 Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Mo Specify: þ Specify 3 Widowed 4 □ Divorced Year or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Truck Driver 12th grade na item 27 is marked othe other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James Richardson Bertha Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is 4 Biehl Court, Owings Mills, Md 21117 Edgar A. Jones-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 3/13/04 Baltimore Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Jhum-4300 Wabash Ave, Baltimore Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, diheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to [or as a consequence of] Examiner cause. Enter Underlying Cause (Disease or injury use as the burial-transit The law requires that the death certificate be executed that initiated events ed by the attending physician and detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 ☐ Yes 2 → No 1 TYes ELYCH RICHARDSON Division of Vital Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 to Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by lospitel or A 4 Homicide within 24 hours aft To the Funerel Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MO 21204 6601 MM Maries 32. Registrar s Signature 31. Date filed (Month, Day, MAR 1 0 2 State Registrar

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Baltimore,	permit. Page Department of Important: If any injury or 2005.		21. Signature of Funeral Service L	censee		C	Name and	L.	Willi	iams	Funera	l Ho	me, P	.A.		
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-	1	9a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Add	ess (Street	and Number o	r Rural Ro	oute Numb	er, City	or Town, Star	te, Zip C	Co <b>d</b> e)
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₹	2	9b. Signature and title of centifier				29c. License	e number			29d. Da	ate signed (Me	onth, Da	ry, Year)
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	30	D. Name and address of person wh	o completed cause of death (	Item 23a) (T	ype, Print)	LE3	, 000			٧*١	v ch 1,	200	77
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Rosalie Wells Servary 2004 Mil /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore tealth care n/a 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 80 Director 216-14-1740 29. 1923 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show event, the Medical Examiner must be notified at Maryland Director 1 ☐ Yes 2 ☐ No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 6831 Montgomery Road Funeral 21075 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12 other Administrator School System permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Anthony Dellape Mary Grillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Servary / Husband 6831 Montgomery Road, Elkridge, Maryland 21075
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 🖾Other (Specify) entomb. Loudon Park Mausoleum 3/13/2004 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Sc 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or comshock, or heart failure. List only ptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician while disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner SLOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (gras a consequence of): Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?\_\_ ģ should b 3 ☐ Probably 4 Donknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 autopsy page this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Division 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours at To the Funeral D completely filled is 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 006050 004 0 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, MAR) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 07282 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 1200 4 **Physician** Ramona Eileen Schimminger was /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Baltimore Health care n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Months 1□M 250 F 234-46-6977 74 Director Oct 10, 1929 West Virginia Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d, Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 534 45th Street 21224 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 □Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Davy Rosa Lillian Shears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Edward Schimminger-Son 534 45th Street, Baltimore, Maryland 21224 Saltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ö Department of Importent: If any injury or once. Maryland Veterans Cem. 3/12/04 Crownsville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on anoth line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to ( > s > consequence of): 68760 the attending physician Physician/Medical use as Box IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Tyes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autoosy performed' 2/7 NO ector, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient Certification: To 2 ER/Outpatient funeral dir 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation М 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide In by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) March 000005 who completed cause of death (Item 234) (Type, Print) Ballymore MD 21 400 Ca 31. Date filed (Month, MAR 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene? 100 in

			1 - For State Registrar	State of	Maryla		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No	-	4	0728	13
			Decedent's Name (First, Middle	Last)		_					2. Date of Dea	ath			3. Time of Dea	th
	Physic /Medi		Sarah	F.	Smitl	h					Month 3	Da	_	)4	9:30 A	M
d.	Exami		4a. Facility Name (If not institution,	give street and num	iber)	_	4b. City, 7	Town, or	Location o	of Death		4c	. County of [	eath		
			2859 Mayfie		(Home				more				N/A			
l	Funeral Director		5. Social Security Number 216–34–8262	6. Sex 1 □ M 2 □ XF	7. Age (In yrs 65	: last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Date 4-4-	h 2 <i>Year)</i> 38	9. Ba	Birthpl Count I t	ace (State or For try) Imore, N	eign Id.
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	ath with the Marylan 23a or 28a-f show ust be notified at	ō			100.0									10	od. Inside City Lin 1 1 Yes 2 □	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 Physician 10:37AM stel 09 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day Year) altimore 6 Liberti If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1□M 27 F Months VIRGINIA 52.20.3590 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or items 23e or 28e-f show 10b. County 10c. City Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "naturel", or items 23e or 28e-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD DAUTI MORE by Funerai Director 10g. Citizen of What Country? ALMAR U.S.H. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 | Never Married 2 | Married 1 ☐ Yes 2 No Specify: BLACK altimore, Maryland 21215-0020 Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL HOUSE KEEPER 17. Father's Name (First, Middle, Last) 11. ATTER BEASLEY 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33Rd STREET BINTO, MO 21218 of Date 20c. Location - City or Town, State 1821 VENABLE /DAUGHTER E. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3.15.04 BATIMORE, MARYLAND DRRAINE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FONERAL HOME 21. Signature of Funeral Service Licenses 4905 YORK ROAD BALTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cardio Vascular Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner 155 attending physician and I for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) 911099 Division of Vital Records, P.O. Box 68760. resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 Ñ No 1 Yes 200 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4K Nursing Home Certification: To 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes investigation 24 hours after death Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

within 24 hou To the Fune completely fi

31. Date filed (Month, Day, Year) State MAR 1 0 2004 Registrar

AMATULI

29b. Signature and title of certifier

ma Jur

(Check only



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

Macam MD

29d. Date signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene, 07285 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 2004 Carol Shippey Sargent March /Medical 6 4:07 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Reisterstown
If Under 1 Year | If Under 24 Hrs. 12232 Dover Road Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 200F Director 424-62-8330 11/3/1958 45 Usual Residence of Decedent iled within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MdBaltimore Reisterstown 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 12232 Dover Road 21136 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fill of Health and Mental History 1 item 27 is marked oth Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked i any injury or other traumatic ev 2 James C. Shippey Martha Jean Waller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12232 Dover Road Reisterstown Robert Sargent Husband MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crem. Service 3/8/2004 Hampstead, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown , Md21136 23a. Part1. Furer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shiptly, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastaria 1/2 year Physician brist owner resulting in death) /Medical Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? for Month Day 5 Other (specify) detached the 9 Unknown 9 Unknown been signed by the should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 5 autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Matural or Attanding 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 7,2004 D40850 0 MID 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR. BALTIMORE MD 21237 TUDNNE OTTAVIANO MD 2. Registrar's Signature 0 2004 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

**ORIGINAL** 

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10	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deeth	
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	Funeral Director		212-24-7982 1	□M 200 F 9	Yrs.	Months Days	Hours Min.	Month, Day, Yel	909 N.C.	arolina.
	and w		Usuel Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or Lo	cation			11	Od. Inside City Limits
	Maryi	tor	MA BAIT	MORE	6	ssex			ì	1 Yes 2 No
	or 288	Olrec	10e. Street and Number	1.0.00		10f. Zip Code		10g.	Citizen of What Coun	try?
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(0	r Item	Funeral Director	11. Marital Status / 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	ĺ		lispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White,	etc.
903	ural', o	b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I □ Yes 2 No	Specify:		Specify: W	rite.
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-1 show atto event. Its Mediral Exercitive court be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of work	ng 16b.	. Kind of Business/Inc	ustry
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aftimore,	of Hear		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of page of page)	(9)	Date 20c.	Location - City or To	wn, Stete
Ĕ	Pages Iment of I tant: If It		1 ☐ Burial 2 🗷 Cremation 3 ☐  3 ☐ Other (Specify	) EVA	INS FU	UERALCH	APEL- 3-	11-04 F	OREST HI	IL, MD
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event. It is Maritial Examiner insert be notified at another.		21. Signature of Funeral Service Licen	30 41	22	. Name and Addre	ss of Facility 3 N	EWPORT	DR., FORE	M, Stete  ILL, M.D  ST HILL, M.D
18			23a. Part1. Enter the disease, or compshock, or heart failure. List only	sevious.	EV	HIOS LOV	SCRALCI	41-41-EL-E	BELAIR,	Approximate
	Physician	į n	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line?	10 m	ite				Onset and Death
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	death he atte	Physician/Me	in the past 12 months? 1 🗆 Yes 2 🕏 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Day Year
О. О	res that the de signed by the a be detached f	Phy	9 ☐ Unknown  Part II. Other significant conditions c		ulting in the un	adorhijas causa sur	on in Part I	23a Did tobaco	o use contribute to the	a cause of death?
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Division of		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	1	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
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	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	(Check only 2 Medical Examone)	iner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my of	pinion, death occurre	ed at the time, date a	(s) and manner as sta ind place, and due to	the cause(s)
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	4		30. Name and address of person who	completed sause of death (Item	23a) (Type, f	21234	DR. H	Raise	n	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure		,			
	Registr	ar	MAR 1 0 2004	persona 1	ly de	200 May				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year MARCH 5,2004 /Medical 10:30A 4a. Facility Name (If not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore Hours Min. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1□ M 2 KF Days 215-14-943 Director May Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Municul Exercities must be notified at Funeral Director 1 ☐ Yes 2 DNo PALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 21234 3016 RNIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Itan any injury or other traumatic event, it a Medical Engine Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mema 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) homa vec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of MD 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State cemetery, crematory or other place, Dukney Valley New Gari 4 □Donation 5 □Other (Specify) 3-10-04 Timonium MO 22. Nam and Address of Facility BALTIMORE, MO 21234. 21. Signature of Funeral Service Licensee VAND FUNERAL 23a. Part1. Enter the disease o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR THROMBOSIS /Medical Due to (or as a consequence of): **Examiner** STAGE RENAL FAILURE END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by been si 2 No 3 Probably 4 Unknown s certificate has b lirector, page 2 si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 241 No autopsy performed? res 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) elli mo 0514 20:4 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. MEHTA M.D. 7601 ER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) MAR 1 0 2004 32 Registrar's Signature State Registrar Darka

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	/Medio Examin	or	4a. Facility Name (If not institution, give : Univ. of Marylar	street and number) nd Medical	Syst.	4b. City, Town, o Baltimo	r Location of Deatl	h	4c. County of	Death	
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	yland 1000		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits	
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				ne cause on each line.				or respiratory ar	rest,	Approximate Interval Between Onset and Death	
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Division	of or Atten after deat Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st cify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,	
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			30. Name and address of person who or Anjali R. Mehta	ompleted cause of death (II	tem 23a) (Type.				Md 212		
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	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 0 2004	32. Registrar's Sig	inarure A	ocally!					

Physician Anna Bollo Spongor Month Day Year			1 - State Amend Item 23 Registrar		aryland/Dep per me G84	artment of 5 rtificate of 1	lealth and I tas Death	Mental Hyg	jiene 19g. No. 20	04	07	28
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Physician (Medical Examiner)  Physic	Pages 1 Iment of H tant: If ite jury or ot		1 Surial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer	natory`or other place					wn, State	
Physician Medical Examiner  The part of the part is an investigation and the part is an investigati	Departition Depart		Enthouy C	Road, D	undalk,	P.A. MD. 2	21222					
FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   yes 2   1   2   Fetal death   3   Ectopic pregnancy   23b. Date of delivery   Month   Day   Year   23b. Was decedent pregnant in the past 12 months?   1   yes 2   1   2   Fetal death   3   Ectopic pregnancy   23b. Date of delivery   Month   Day   Year   23b. Was decedent pregnant in the past 12 months?   1   yes 2   1   2   Fetal death   3   Ectopic pregnancy   23b. Date of delivery   Month   Day   Year   23b. Date of D	/Medical Examiner	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events	Due to (or as a	a consequence of):							
25. Was case, red to medical examiner?  10	the death certific the attending p ched for use as	ysiclan/Med	23b. Was decedent pregnant in the past 12 months?	1 □ Live birth 2 4 □ Pregnant at	2 ☐ Fetal death 3 ☐		CERTIFICA	TION PPROVED B	23d. Date Mont	ot deliver	-	'ear
25. Was case, red to medical examiner?  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manney of Death 1 Natural 2 Red to Injury at Work?  28. Place of Death (Check only one)  28. Place of Death (Check only one)  27. Manney of Death 1 Natural 2 Red to Injury at Work?  28. Place of Death (Check only one)  28. Place of Death (Month, Day Year)  28. Place of Death (Month, Day Year)  28. Place of Death (Month, Day Year)  28. Place of Death (Month, Day Year)  29. Signature and title of centifier  29. Date signed (Month, Day Year)	quires that I n signed by uld be deta	þ		tributing to death bu	t not resulting in the un	nderlying cause give	n in Part I.					
Yes 2 No	an: The law re tificete has bee tor, page 2 sho		25. Was case regret to medical		spinal ab	normality	26. Place of Deat	autops perform 1 Yes 2	pri de No 1	ior to com ath?	pletion of ca	vailable use of
29a. Certifier (Chack only one)  29a. Certifier (Chack only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and advess of person who completed cause of death (Item 23a) (Type, Print)	ding Physici h. After this ce funeral direc	၉	27. Mannar of Death  1 Matural 5 Pending	1 Unpatier		28c. Injury Work	at ?	me 5 Reside	nce 6 Other			
29a. Certifier (Chiex with one)  29a. Certifier (Chiex with one)  29a. Certifier (Chiex with one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and advess of person who completed cause of death (Item 23a) (Type, Print)	tel or Atten s after deat el Director: ed in by the	Certifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injubulding, etc.	ry - At home, farm, stre (Specify)		63 2 110			or Rural	Route Numb	er,
29c. License number 29d. Date signed (Month, Day, Year) 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print)	the Hospi in 24 hou the Funer ipletely fill	edical	one)	er: On the basis of	examination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and mann te and place, an	ner as sta id due to t	ted. he cause(s)	
30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print)	with To I	2										_
State 31. Date filed (North Day Year) 32 Registrar's Signature	4		Christo, w Jeh	no 114	ath (Item 23a) (Type, I	Harore	or Street	of Jell	more 11	00	21230	,

			1 - For State Registrar	State o	of Maryland	d / Depart <i>Certi</i>	ment of Hea	olth and M	ental Hy	giene Reg. No. 200	4 07290
	Physic	ian	Decedent's Name (First	t, Middle, Last)					2. Date of De. Month	ath Day Ye <i>a</i> r	3. Time of Death
	/Medi Exami		Durward  4a. Fecility Name (If not in.	Lec stitution, give street and nur			rter b. Cily, Town, or Loc	ation of Death	3	4c. County of De	
			FRANKlin	SqUARE HE	ospiTA 1		Rosed	14/0		BAITI	
	Funeral Director		5. Social Security Number 718–18–1898	6. Sex 1 M 2 □ F	7. Age (In yrs. la	86 Yrs.	f Under 1 Year   If I	Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da March	h y, Year) 9. Bi	rthplace (State or Foreign country)
	land bw		Usual Residence of Deced	dent County	10c. City	, Town or Locat	ion				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	tor	MD. Bai	ltimore		undalk					1 ☐ Yes 2 X No
7	or 28e	lirec	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	Country?
	ath w	ral	1720 Drexel				21222			USA	
S 11 C.M.	<u> </u>	by Funeral Director	11. Marital Status  1 Never Married 25  3 Widowed 4 Di	Armed Fo	2 □ No /e	If Y	s Decedent of Hispares, specify Cuban, M Yes 2 <b>X</b> No Sø	nic Origin? (Spec exican, Puerto F pecify:	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
5.0036	72 hor	ted	15. De	ecedent's Education v highest grade completed)		16a. Deceden	's Usual Occupation			16b. Kind of Business	s/Industry
7 2	ne.	Completed	Elementary/Secondary (		I-4or 5+)		d of work done during NOT use retired)	g most of workin	9		
wARC and 21	Hygie ther t		8 years 17. Father's Name (First, A	Middle, Last)		Millr		Mother's Name	/Eirat Adidulla	Steel	
8 >	d Mental in marked o	To Be	Durward Edwa	ard Shorter				Hattie	Dunn	Maiden Sumame)	
Mai	id 2 st lth and 27 is r traur		19a. Informant's Name/Re		wife		ddress (Street and P			r, City or Town, State,	Zip Code)
Baltimore,	iges 1 ar nt of Heal iff Item 3 or other	1	20a. Method of Disposition 1 XBurial 2 ☐ Crem	nation 3 Removal from t	20b. Pla		on (Name of ory or other place)	Da		20c. Location - City or	Town, State
Ħ	iit. Pa artmer artant njury		^ 4 ☐ Donation 5 ☐ Of 21. Signature of Funeral S		Garde		ith Cemetery	$r \perp 200$	4 F	Rosedale, M	ID.
Ba	permit. Departi Importi any inj	7	Yntho	ray C. Co	mel	ly cor	nelly Fun 0 Sollers	eral Hor Point I	ne Of D Road, D	oundalk,P.A Oundalk,Md.	21222
8760,	Physician /Medical Examiner prize pe executed the prirat-transit the prirat-transit price per per per per per per per per per pe	icai Examiner	shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediat cause. Each property that initiated events resulting in death) Last	b. Due to (	or as a conseque or as a conseque or as a conseque	ence of):					Approximate Interval Between Onset and Death
O. Box 6	t the death certific by the attending parched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	1 Live bi	come of pregnand inthe 2 Fetal cant at time of dealers	leath 3 ⊟Ect	opic pregnancy ner (specify)			23d. Date of de Month	livery Day Year
ords, P.	w requires tha been signed I should be det	þ	Part II. Other significant co	onditions contributing to de	ath but not result	ing in the under	lying cause given in l	Part I.	23e. Did to	pacco use contribute to es 2 No 3 □ Pr	o the cause of death?
Division of Vital Records,	; The law r cate has be ; page 2 sh	Completed							24a. Was a autops perform	y prior to med? death?	atopsy findings available completion of cause of 2 No
, ≤	Physician; Th this certificate ral director, pag	o Be	25. Was case referred to mexaminer?	Hospital:			0#	Place of Death (			Trong and the second
of	Phys ar this aral di	$\vdash$	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		R/Outpatient 3 8b. Time of	28c. Injury at			ence 6 Other (Special of the Control	cify)
ion	Attending Fir death. ector: After by the funer	ation		Pending (Month nvestigation	h, Day Year)	Injury	Work? И 1 ☐ Yes		a. 2000/100 No	w injury occurred	
Divis		ertification:		Could not be determined 28e. Place buildin	of Injury - At homing, etc. (Specify)	e, farm, street,	factory, office	28	f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	edical C	29a. Certifier (Check only 2 Me	ortifying Physician: To the leadical Examiner: On the baland mann	sis of examinatio	edge, death occ n and/or investi	curred at the time, da gation, in my opinion	te and place, an , death occurred	d due to the ca at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Complet		29b. Signature and title of	ertifier & Of	-1		29c. License num	ber	25	9d. Date signed (Montl	h, Day, Year)
			Jun	- J. The	le mi	2	D009	5772	1	3/8/0	4
	in		30. Name and address of pe	erson who completed cause	of death (Item 2	3a) (Type, Print	)	error at the contract of	-3-	NASYA SZESTA	==
	Sta	e	31. Date filed (Apprin Day)	Year) 26. Re	igistrar's Signatur	· Squa	RE DR.	UAllim	VIE /	10 2100	7
	Registr	7.6	WHR I	0 2004	in B	bout				MA 2123	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Day Calvin Warren Straughn, Jr 3 2004 /Medical 2:45 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Milford Manor Pikesville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<del>∏</del> M 2□ F 578-48-3235 Director 10-18-1937 Md Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified as once. Be Completed by Funeral Director 1 ☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5527 North Green Road 21244 U S 12. Was Decedent Ever in U.S. Armed Forces? 1 EYes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)/A Elementary/Secondary (0-12) NBC Channel 4 News Stage Manager 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin W, Straughn Audrey Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Finch Drive Landover, Md 20785 Terrance Straughn - Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 3-12-2004 Owings Mills, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Down 4300 Wabash Avenue Balto, Md 21215 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, bacong to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) the attending physician and shed for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? director, page 2 should be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 7 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Dey, Year) 29c. License number un 30. Name and address of ded cause of death (Item 23a) (Type, Print) eman 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

the Mary

filed within 72 hours after death

Baltimore, Maryland 21215-0036

must be notified.

event, the Madical Exeminer

Funeral

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Physician/Medical

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Certification:

Medical

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permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any njury or other traumatic event, the 2010s.

Physician

/Medical

**Examiner** 

the burialphysician

the Hospital or Attending Physician: The law requires that the death certificate be executed

After this

death.

within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760

amend 8, 8 per F.H. g855 5/11/06 KBH

> Places Type or Print in Black Indelible Ink Encure All Copies Are Legible

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7	49,64	1. Decedent's Nam							2. Date of Death Month	Day	Year	3. Time of	Death
	Physician /Medical	Та	ylor	D .		Streete	r		Februar			348	a M
0		,		n, give street and nu			4b. City, Town, or	r Location of Death		4c. County	of Death		
		Prince G	eorges	Hospital	Cent	er	Chever.	ly				orges	
8	Funeral	5. Social Security N		6. Sex	7. Age (	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthp	place (State o	or Foreign
8	Director	216-67-	4870	1 □ M 2 □ X		Yrs.	7 10		July 1	$\frac{5}{5}$ , $\frac{20}{10}$	03_	Wash	DC
7	0	Usual Residence o	Decedent										
9	M TH	10a. State	10b. County	1	1	Oc. City, Town or Lo	cation				1	10d. Inside C	ity Limits

MD Director 10e, Street and Number 5012 57th Ave #C5 Bladensburg 10f. Zip Code

1 XYes 2 No 10g. Citizen of What Country?

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 XNever Married 2 ☐ Married 3 Widowed 4 Divorced Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🗓 No Specify

20710

14. Race - American Indian, Black, White, etc. Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A

P.G.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

U.S.A.

16b. Kind of Business/Industry

20c. Location - City or Town, State

Streeter

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

Tijuan Brown 19a. Informant's Name/Relationship (Type, Print)

Tonnette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonnette D. Streeter -Mother 5012 57th AVE #C5 Bladensburg, MD 20710

20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill

N/A

02/20/2004 Suitland, MD

21. Signature of Funeral Service Ucens

Austin Royster Funeral Home 14th ST, N.W. Wash, DC 20011

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Asphyxia Due to (or as a consequence of)

Overlay

Due to (or as a consequence of)

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

X Yes 2 No

27. Manner of Death

□Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death

4☐Pregnant at time of death 9 Unknown

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Approximate Interval Between Onset and Death

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death? 3 Probably

24a. Was an

24b. Were autopsy findings available prior to completion of cause of

2 No Yes

death? 2□No

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury 2/14/04 2/14/04 1 ☐ Yes 2XXNo  $\mathbf{p}_{\mathsf{M}}$ overlay Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1233 Nalley Rd, Landover, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified

29c. License number OCME

Injury

29d. Date signed (Month, Day, Year) February 15 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

residence

M.D JACK Who 31. Date filed (Month, Day, 1) 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

			1 - For Amend Item 24	State of a per Verb.,	Marylar 829,03/	nd / Depa /10/04dbl	artmeni <i>Hificate</i>	t of H	ealth and Death	Mental H	ygiene Reg. No.	2004	072	93
			Decedent's Name (First, Midd					-		2, Date of	Death		3. Time of	Death
	Physicia /Medic		Rosalind Ann	Sheppard						Febru	ary 2	6, 2004	5:15	P M
	Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of De	ath		County of Death		
			Greater Balti				Tows	_		(- <u>-</u> -		ltimore		
	Funeral		5. Social Security Number	6. Sex 7		. last birthday) Yrs.	If Under Months	Days	If Under 24 H Hours M	in. (Month,	Day, Year)	Cot	place (State o	r Foreign
1	Director		217-50-4735 Usual Residence of Decedent	^	58		1			June	8 194	5 M	)	
2	yland now		10a. State 10b. County	1	10c. C	ity, Town or Lo	ocation						10d. Inside C	•
" )	Mary Ba-f ah	tor	MD Balt	imore	Ti	moniun	n						1 🗍 Yes	2 <b>X</b> No
4	or 28	Director	10e. Street and Number				10f. Zip	Code			10g. Citi:	zen of What Cou	intry?	
5	ath wi	rai	1817 Eastridge						1093			USA		
Sosalina	er dek	Funerai	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	<ol> <li>Race - Amer Black, White</li> </ol>		
36	rs aft	by F	Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give			1 ☐ Yes	<b>₩</b> No	Specify:			Specify: W	nite	
5-0036	within 72 hours after death with the Maryland liene. rithen "natural", or tems 23a or 28a-f ahow It a Medical Exarta wit must be collined at		15. Deceder	nt's Education		16a. Dece	dent's Usua	il Occup	ation		16b. Kir	nd of Business/I	ndustry	
ج 215	⊆ ∰	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-	4or 5+)	life.	DO NOT us	nk done d se retired	luring most of v )	vorking				
04KD		Completed	n/a	n/a		Shelte	ered	Work	Shop			Contra	ctor	
d E	be filed stal Hygid od other	Be	17. Father's Name (First, Middle,	Last)						Name (First, Midd		Sumame)		
<(2) ylan		To.	Ross Douglas			401 44 11		(0)		e Knofle		· T Ot	'- O-d-1	
$h < 1 > \rho$ Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relation							Rural Route Nur				
	1 and Health and 1		Natalie Sheppa 20a. Method of Disposition	ra/motner	20b.	Place of Disponentery, cre	East in osition (Nan	riag	е ка.,	Timonit Date		cation - City or 1		
^ or	5 5 5		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		iale				etery 3	12/01	Pal	timore,	MD	
altimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service	The second second	1 1	2	2. Name an	d Addres	s of Facility					
Ba	imp pen		Michael J.	Elagle	_	11	emmo	n F	uneral	Home of	Dula	ney Val	ley, Ir	ıc.
	57 196		23a. Part1. Enter the disease, or shock, or heart failure. Lis	r complications that ca	used the dea	ath. Do not en	ter the mod	e of dyin	g, such as card	liac or respirator	arrest,	19112 21	Approximat Interval Bet	е
	Physician		Immediate Cause (Final disease or condition	0	umo	mia							Onset and	Death
	/Medical		resulting in death)		ras a conse								حر المارات	
	Examiner		Sequentially list conditions.	b										_
	Sit 3d	iner	Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consu	cuanda uf):								
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (c	r as a conse	quence of):								
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687	ficate phys s the	edicai		d										
Вох	death certifica attending ph d for use as ti	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregr	nancy	35				2	3d. Date of deli-	<i>е</i> гу	
, m	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	th 2 ☐ Fet int at time of		□Ectopic pr □ Other (sp				-	Month	Day '	Year
40	that the d ed by the detached	hys	9 Unknown	9□ Unknov	wn								-	
S.	es tha	by F	Part II. Other significant condit				underlying ca	ause givi	en in Part I.			se contribute to		
L P.	w requir been si should	ted	Down's	Syndro	me	-				- 1	Yes 2	2N0 3 Pro	babiy 4 🗆	JUKUOMU
ec	a taw has b	Completed								_ 24a. W	topsy	24b. Were aut	opsy findings ompletion of c	available ause of
<u> </u>	: The	Cor					=			1 ☐ Ye	informed? 24 No	death? 1 ☐ Yes	2 No	
Vita	sician: The taw certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Oth	25	Death (Check on				
ð	Physician: The la r this certificate has ral director, page 2	٦.	1 Yes 2 No	1 🗀 In		28b. Time of			4   NUISIN	g Home 5 🗍 Re			ify)	
e u	ding Ph th. : After th funeral	tion	1 ☐Natural 5 ☐ Pendi	ng 28a. Date of (Month)	, Day Year)	Injury	М	8c. Injury Worl	<br Yes 2 □No					
Division of Vital Record	Attent deal	Certification;	3 Suicide 6 Could	not be 28e. Place	of Injury - At I	home, farm, st	reet, factory	, office			(Street and Town, State)	d Number or Ru	ral Route Num	ber,
وَ	s afte	Cert	4 _ Homicide	bullain	g, etc. '(Spec	ary)				City of	own, State,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerat Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier 1 Certifyi	ng Physician: To the l	pest of my kn	nowledge, dear	th occurred	at the tin	ne, date and pla	ace, and due to the	ne cause(s)	and manner as	stated.	
	the H in 24 the F	ledi	one)	and mann	er stated.	1210112110011				Dodnoo at the th				
	To To	Σ	29b. Signature and title of certifi	06			1		o number	59	1	$\frac{2}{2}$		
	1)		(duan	4 830m	2					89	1			
	4		30. Name and address of person	who completed cause	ot death (Ite	om 23a) (Type Charl	Print)	2	Such	e 601	70	erson b	Mad 2	1204
	Sta	te	31. Date filed (Month, Day, Year		gistrar's Sigr									
	Registr		MAR 1 0 200	na Se	10	frank.	. 0							

Physici		1 - State Amend Item 23a p Registrar  1. Decedent's Name (First, Middle, La Edward John			inca	ie of L	Jean	1	2. Date of De Month March	ath Da		3. Time of 0	
/Medic Examin	al -	4a. Fecility Name (If not institution, gived 14997 Health Cent	street and number)		4b. City BOW	Town, or	Location o		March	40	. County of [		A
Funeral Director		5. Social Security Number 6. S		s. last birthday)		r 1 Year	If Under a	Min.	B. Date of Bir (Month, De IAY 21	th y, Year)	9.	Birthplace (Stete or Country)	Foreig
f show	tor	Usuel Residence of Decedent  10a. State  10b. County  Maryland Prince		City, Town or Lo	ocation							10d. Inside Cit	
3a or 28a- at by notif	i Director	10e. Street and Number 14997 Health Cen		7		ip Code )716				10g. Ci	tizen of Wha	t Country?	
naturel', or Itame 23a or 28a-f ehow Jigal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates:		Was Dec If Yes, sp	ecify Cubar	spanic Origin, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No ican, etc.)	)-		American Indian, White, etc. Whit	te
than the Me	Completed	15. Decedent's E (Specify only highest gr.	ducation ide completed)  College (1-4or 5+)	16a. Dece (Give life. Polic	kind of w DO NOT	ual Occupa rork done d use retired) ficer	tion uring most	t of working	9		of Busin	ess/Industry Governmer	nt
ind Mental Hygin marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last Jacob Sutter							(First, Middle		n Surname)		
h and 7 is m traum		19a. Informant's Name/Relationship (George E. Sutter	/Son	370	5 Id	olsto		ine I	Bowie,	MD	20715		
		20a. Method of Disposition  1 Burial 2 XCremation 3 C  4 Donation 5 Other (Speci	Removal from State	Place of Dispo cemetery, cre etro Cr	matory or	other place		3-1-	04			y or Town, Stete ore, MD	
Department Important: I any injury o		21. Signature of Funeral Service Licaron Thomas Green	- Live	2	<sup>2.</sup> Cre 299	nattion Fred	ho 500 erick	ety Road	of MD d Ba	In ltim	ic. nore, N	MD 21228	
hysician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Renal	Failur		ode of dying	, such as	cardiac or	respiratory a	irrest,		Approximate Interval Betw Onset and D	Neen
xaminer	Examiner	Sequentially list conditions, Tary, leading to miniodial cause. Enter Underlying Cause (Disease or injury that initiated events	b. Hyperter  Due to (or as a cons	sion									
physician and sthe burial-transit	cai	resulting in death) Last	Due to (or as a cons	equence of):									_
The law requires that the death certificate or executed life has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3	□Ectopic □ Other (	pregnancy specify)	-				23d. Date o Month	,	ear)
been signed b	þ	Part II. Other significant conditions	contributing to death but not r	esulting in the u	underlying	cause give	n in Part I					ite to the cause of de	
	Completed							_	24a. Was auto perf- 1 Yes		prio	re autopsy findings a r to completion of ca th? Yes 2 \sum No	availa
certific rector.	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	int 3□I	Othe Othe	100	of Death	(Check only		6 Other	(Specify)	
a fe	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not			М		at (? (es 2 🗆	No	8d. Describe			Control Control November	
to the nospite of Attentions within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certifi	4 Homicide determined		cify)			o data an		City or To	wn, Stat	te)	or Rural Route Numb	<i>561</i> ,
in 24 ho he Fun pletely f	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or i	nvestigati	on, in my op	oinion, dea	ith occurre	d at the time	, date ar	nd place, and	I due to the cause(s)	)
Tot	×	29b. Signature and title of certifier	MD			9c. License	humber 689				rch 1,	2004	
		30. Name and address of person who		tem 23a) (Type			Swit	- 7-	,	>		20716	

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State of Maryland	/ Department of He	ealth and Me	ntal Hygien	e	IJ

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Robert Gilbert Stone March 4, 2004 12:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda
If Under 1 Year | If Under 24 Hrs. 4925 Battery Lane #803 Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs. Director 041-22-1514 75 September 9, 1928 Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov nutified at 1 ☐ Yes 2 No Directo Maryland Bethesda Montgomery the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? With r than "natural", or Items 23a or the Medical Examinar must be 4925 Battery Lane #803 20814 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Peges 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
The filem 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examination by or other traumatic event, the Medical Examination. 1 ☐ Yes 2 No 48
If Yes, Give 1948
Year or Dates: 1952 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Astrophysicist NASA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4908 Bradley Boulevard Chevy Chase, Maryland 20815 Fern Stone/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permil. Peges 1
Department of Iimportent: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. ` 4 ☐ Donation 5 ☐ Other (Specify) March 7, 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service License once. M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Laz Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endstage Liver Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has burnector, page 2 s autopsy performed? 1 Yes 2 No To the Hospitel or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 4, 2004 D-31319 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Loreto S. Albiol, M.D.

1

0 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

8218 Wisconsin Avenue #305 Bethesda, Maryland 20814

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FFMALE   23d. Nas decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	right o	/Medical Examiner		Immediate Cause disease or condit resulting in death Sequentially list of frany, leading to cause. Enter Und Cause (Disease of that initiated even	(Final long)  conditions immediate lerlying or injury ts	a. CON  Due to (c)  Due to (c)  C.	or Shv or as a consec d s food	C MCQV quence of): C MCM quence of):	+ fail	urc			Onset and Death
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24a. Was an autopsy performed?    Compared		that hed b deta	4 P	Part II. Other sign	ificant conditions	contributing to de	ath but not res	sulting in the u	inderlying cau	se given in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
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by the participation of the pa	ō	Phy r this raid	<del> </del>			28a. Date o	f Injury						
by the participation of the pa	o	th. The	ig				i, Day Year)	Injury					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVHWEST HOSPITAL  Manying Mejia 5401 Old court Road Organings Mills, MD  31. Date (Ited (Month, Day Year) 32. Registrer's Signature? Applications	Divisi	I or Atten after dea Director d in by the	ertifica	3 Suicide	dataminad	288. Place			reet, factory, c	ffice			er or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVHWEST HOSPITAL  Manying Mejia 5401 Old court Road Organings Mills, MD  31. Date (Ited (Month, Day Year) 32. Registrer's Signature? Applications		ne Hospiti n 24 hours ne Funera	edical C	(Check only	1⊠ Certifying Pi 2  Medical Exa	niner: On the ba	sis of examina	owiedge, deat ation and/or in	h occurred at ovestigation, in	the time, date and plac my opinion, death occ	ce, and due to the courred at the time, o	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVHWEST HOSPITAL  Manying Mejia 5401 Old court Road Organings Mills, MD  31. Date (Ited (Month, Day Year) 32. Registrer's Signature? Applications		Withir To the comp	ž	29b. Signature an					29c. L	icense number	2	29d. Date signed	(Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOrthWest Hospital  Manjay Mejia 5401 Old court Road Organias Mills, MD  31. Date (ited (Month, Day Year) 32. Registrar's Signature 1				M	ugre	J MD					1	naran	4,2004
Manjay Majia 5401 Old Court Road Organing Mills, MD		13		30. Name and add	200	completed cause	of death (Ite	m 23a) (Type,	Print) NO	rtuwest the	spital		•
State 31. Date filed (Month, Day, Year) 32. Registrate Signature Signature		1		Manja	Mejia	5401 01	docurt	Rogal	Dyring	& Mills, MI	2		
		Sta	ite	31. Date filed (Mo	onth, Day, Year)	32 Re	gistrar's Sign	ature	Spork	s ,			

State of Maryland / Department of Health and Mental Hygiene 2004 07297 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 6, 2004 4:02 A Amir Bahadur Shrestha /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**∑** M 2□ F 69 Yrs. 1934 Nepa1 622-40-7629 June 11, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 807 Stonington Road 20902 Nepal Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 X Widowed 4 Divorced Asian Nepalese "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Government of Nepal than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Pharmacologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Yagya Bahadur Shrestha Mithai Nani Maskey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 807 Stonington Road, Silver Spring, MD 20902 Rajendra B. Shrestha/ Son 20b. Place of Disposition (Name of comptent crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition Date March 8, permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Li enses çonsin Avenue, M00689 frient disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Approximate Interval Between Onset and Death 23a. P. rt1 Emerthe dis si oc. pe an ailu Immedime Cause (Final disease or ondition Metastatic Cholangiocarcinoma 4 months Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760. the attending physician Physiclan/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown cate has been signed by , page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 🛛 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier D33224 March 6, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram S. Trehan, M.D. 50 W. Edmonston Drive, #303, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 0 2004 Registrar

DHMH 17 Rev 1/2001

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MES	THOMPS	ON	JR. For 1- State ANGENT TOTAL				Health and Mo		200	1. 07200
	Physici	an	1 - State Registrar AMEND ITEM  1. Decedent's Name (First, Middle, I	#20a PER FH G8	3/10/04	ertificate of		2. Date of Death Month	Day Ye	3. Time of Death
	/Medic Examir	al	4a. Fecility Name (If not institution, g		pson		or Location of Death	MARCH	8, 2004 4c. County of D	1300 P M
			3034 ARUNAH AVE		In yrs. laist birthda		ORE CITY	8. Date of Birth	IVIA	Birthplece (State or Foreign
	Funeral Director		214-64-7841 Usual Residence of Decedent	10M 2□F	49 Yrs.	Months Days	Hours Min.	Month, Day, 1	1954 N	Country) and
	the Maryland r 28a-f show	or	10a. State 10b. County	) 1	Oc. City, Town or Baltim					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	hours after death with the Maryland ural', or Items 23a or 28a-f show al Examinar mual be notified at	Funeral Director	3034 ARUNAI	n Ave.		10f. Zip Code	/a	100	g. Citizen of What	Country?
	r death	ınerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	3. Was Decedent of H	Hispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-	14. Race - A	merican Indian, /hite, etc.
9036	hours afte tural', or It al Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced			1□ Yes 2☑No	Specify:	,,	Specify:	Black
ιγ̈́	in 72	Completed	15. Decedent's (Specify only highest of	rade completed)	(Gir	. DO NOT use retire;	during most of working	g 16	6b. Kind of Busine	ss/Industry
1212	e filed within all Hygiene.  other than "	Com	Elementary/Secendary (0-12)	College (1-4or 5+)	Neu	ier work	red	(5)	IVIA	
Maryland	a la b	To Be	James M. T	hompson			18 Mother's Name	Duri	20 t	
	nd 2 state are trau		19a. Informant's Name/Relationship	(Type, Print) INSON - QUI		iling Address (Street Darii	and Number or Rural 19 ton Rd.	Bolto Number, o	Dity or Town, State	e, Zip Code) 204
nore	ages 1 a nt of Hea t: If Item / or othe		20a. Method of Disposition  Theorial 2 Commation 3	Removal from State	20b. Place of Dis cemetery, cr	position (Name of ematory or other place	Ce) 3-13	te 20	c. Location - City	or Town, State
Baltimore,	permit. Pages Department of I Important: If Its eny injury or o	1	* 4 □ Donation 5 □ Other (Special Service Up			22. Name and Addre	ess of Facility		11.11.0	10,1110
	20500	11/	23a. Party Enter the disease, or co	mplications that caused the	e death. Do not e	nter the mode of dyin	arch F/H &		thilten Pa	Approximate Interval Between
F	Physician /Medical		shock, or yeart failure. List on Immediate Cause (Final disease or condition resulting in death)	a intrace	rebra	1 hema	xchage			Onset and Death
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687	Jeath certificate to attending physical for use as the to	Medic	IF FEMALE:	d						
		Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of particle birth 2 [ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date of Month	delivery Day Year
Is, P	es pe pe	by	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause giv	ren in Part I.			e to the cause of death?  Probably 4 DUnknown
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_ '	ate h	Com						autopsy performe 1 Yes 2	d? death	
Vital	Physician: The this certificate all director, pag	o Be	25. Was case referred to medical examiner?  1 X Yes 2 □ No	Hospital:	2 ER/Outpati	ent 3 DOA Oth	26. Place of Death	- 21 0000	e 6 XOther (S	pecify) AT SCENE
o uc	After	Ion: T	27. Manner of Death	28a. Date of Injury (Month, Day Yo	ear) 28b. Time Injury	of 28c. Injur Wor	y at 28	d. Describe how		poory, III COLLIE
-	or Attendent fter death irector: n by the	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	ho	- At home, farm, s Specify)	street, factory, office	Yes 2 □No	If. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
-	to the hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Cartifying R (Check only one) Cartifying R	Physician: To the best of n aminar: On the basis of ex and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, ar pinion, death occurred	d due to the caus d at the time, date	se(s) and manner and place, and c	as stated. lue to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	arni-	-2000	29c. Licens	e number •M•E		Date signed (Mo	onth, Day, Year) , 2004
	9		30 Name and address of person wh	1211			D 71.1		,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Cimpotuna		, Baltimor	e, Maryl	and 2120	1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 () 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:10 P.M March 2004 Kenneth Leroy VanMeter, Jr. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 325 Rose Ave. if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours XXM 2 F Maryland Director 215-80-5463 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exercitive most be notified at 1 Yes 2X No Maryland Anne Arundel Glen Burnie Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 United States 238 325 Rose Ave. 21061 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Yes 2/2/No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ŏ Specify: White 1 ☐ Yes 3€ No Specify: þ 3 - Widowed 4 - Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 11 Disabled marked other Ith and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Patricia Ann Leonard Kenneth Leroy VanMeter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traum Roger VanMeter / Brother 934 Blue Ridge Dr. Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marchail0, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen HAven Mem. Pk. 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 6ASTRIC ADENO CARCINOMA **Physician** 5 MONTHS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transi certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ę 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 🗌 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 20XNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) Certification: To 1 Yes \_ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA s after deam. el Director: After thi 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by the 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 025559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH CRAIN HWY, 6-LEN BURNIE, MD 21061 1307 MD 32. Registrar's Signature State Registrar

		For State	State of	f Marylan		artment of I	Health and I			SOUL	. 07201
£		Registrar  1. Decedent's Name (First, Middle, La	st)		061	incate of	Dealit	2. Date of Death	g. No. 🔏	_ U U L	3. Time of Death
Physicia	1	Vernon 5.	Vavrin	2				March 07	. <sup>Day</sup>	]4	6:00 PM
/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location of Deat		4c. Co	unty of Death	
		Gilchrist				Towson			Bal	timore	
Funeral Director		214-40-6967	Sex IN 2□F	7. Age ( <i>In yr</i> s. 90	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, May 25,	<sup>Year)</sup> 1913	Cou	plece (State or Foreign intry) cyland
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				T	10d. Inside City Limits
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death with the Maryland rms 23e or 28e-f show	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen	of What Cou	intry?
th wit		8820 Walther Bl	vd. #36	02		21234				USA	
rs after death with the Marylar I, or Nems 23e or 28e-f show Karrens could be coulded at	Funeral	11. Marital Status	12. Was Dece Armed For	edent Ever in U rces?	.S. 13. \	Was Decedent of f Yes, specify Cult	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- to Rican, etc.)		Race - Amer Black, White	
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within 72 hours after ene. than "natural", or Ite he Medical Exametra		15. Decedent's E	ducation		16a. Deced	dent's Usual Occu	pation		16b. Kind o	of Business/Ir	ndustry
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ad wit giene ar the	Completed		+5		Depu	ity Super	rintenden				ic Schools
be file d oth	Be	17. Father's Name (First, Middle, Last	)				18. Mother's Nar	ne (First, Middle, M nce Heal		mame)	
d Men narke natic	<sup>L</sup>	Frank Vavrina  19a. Informant's Name/Relationship	(Type Print)		19h Mailir	on Address (Stree	t and Number or Ru	<del>.</del>	<del>-</del>	own State Zi	n Code)
nd 2 sl lith an 27 is r r traur		Mrs. Gertrude Vav		life		-	Blvd. #:		-		
s 1 ar if Hea item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other pla	3C0)	Date 2	20c. Locati	ion - City or T	own, Stete
Page nent o int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Qther (Speci				Mem. Pa		2-2004	Syke	esville	e, Md.
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Department of Innortant: If Item 27 is marked other than "natural; any injury or other traumatic event, the Nedical Exagnee.		21. Signature of Fineral service Lice	nsae		22	Name and Addr	ess of Facility DWSON FUNC ORK Rd. To	eral Home	, Inc		
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after Direction by	Certification:	4 ☐ Homicide determined	buildi	ng, etc. (Speci	fy)	eet, factory, office		City or Town	, State)	211201 01110	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	(Check only 2 Medical Exa	miner: On the ba	asis of examina			time, date and place opinion, death occi				
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8 4 8 4		Maharl	~			0	(73m	1	rard	182	lody
1741		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)	30703			182	ı
10.11		Auran J. Charles	on.	6601	NJC	lades	st B	alternore	me	2150	4
Sta Regist	ate	31. Date filed (Moeth, Ray-Year) 21	)04 32 A	legistrar's Sign	ature	and I					

			1 = For State Registrar	State of Ma	arylan	nd / Dep	artme ertifica	nt of H	lealth and Death	Mental	Hygiei Reg.	ne 2 0	04	073	02
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	se-f show	ector	Usual Residence of Decedent  10a. State Maryland Montgome	ery		y, Town or L yy Cha	se							0d. Inside City	
	th with the 23a or 2	Funeral Director	10e. Street and Number 4242 East-West H	ighway, #81	.5			ip Code 20815			- 20	Citizen of \ ited		•	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:		.S. 13.			ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes nto Rican, etc	or No-	14. Rac Blac Specifi	e - Americ ck, White, V: Wh	an Indian, etc. ite	
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aryla	should nd Men marke umatic	ပ	Antoine Pierre Va  19a. Informant's Name/Relationship			19b. Mail	ing Addres	ss (Street a	Suzanne and Number or F			y or Town,	State, Zip	Code)	
Baltimore, Maryland 21215-0036	es 1 and 2. of Health a fitem 27 is r other trau		Nancy Pyeatt/ Fri  20a. Method of Disposition  t □ Burial 2X Cremation 3 [		20b. P		East	-West	Highwa		5, Ch		Chase	, MD 20	0815
Baltim	permit. Pages Department of I Important: If it eny injury or o		4 Donation 5 Other (Special Signature of Funeral Service Co	(y)	Ure	mator	Lum, 2. Name a	Lnc. Ind Addres	20 ss of Facility R nevy Cha sda, Mar	04 obert	A. P11	mphre	2 T11	ryland neral H sin Ave	Home/
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$\widetilde{\star}$ Division of Vital Records, P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	⊒Ectopic p ⊒ Other (s					23d. Dai	e of delive	ry Day Ye	ar
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ion of	nding Physician: The lath. T: After this certificate hate funeral director, page	atlon; To	1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigatio	28a. Date of Injur (Month, Day		28b. Time o Injury		28c. Injury Work	4   Nursing		Residence ribe how in			)	
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	the Hosp ain 24 hou the Funel npletely fil	Medical	(Check only 2   Medical Example one)	nysician: To the best o miner: On the basis of and manner stat	examina	wledge, deat tion and/or in	vestigation	n, in my op	oinion, death occ	e, and due to urred at the t	ime, date a	ind place, a	and due to	the cause(s)	
	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	~	29b. Signature and title of certifier	6. Nea	lor	~ M	. () D	2312				oate signed rch 9			
	/ "		30. Name and address of person who Kevin G. Nealon,					ue,	#925. CH	evv Cl	iase.	MD 20	0815-	4330	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2004	32. Registra	r's Signa	ture		K							

			1 - For State Registrar	State of Marylar		rtment of H		Mental Hygier	- 201	04 07303
}	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las     A		Wit.	Liams 4b. City, Town, or	Location of Deat	February	Day Year 29 20 4c. County of D	04 00.30 AM
	Funeral Director		5. Social Security Number 423.34.0465  Usual Residence of Decedent	ACINS FOSPH DX 2015 7. ASSO (In yrs.		If Under 1 Year   Months Days	Merc C If Under 24 Hrs Hours Min.	442 4 5	728 A	Birthplace (State or Foreign Country)
	death with the Maryland ms 23a or 28a-f show rmal be notified at	ctor	10a. State 10b. County	10c. Ci	BACTI	MORE	-			10d. Inside €ity Limits 1 Yes 2 No
	th with th	ai Director	10e. Street and Number 703 N. CUR	LEY STREE	=+	10f. Zip Code	21205		Citizen of What	Country?
036	ours after ral', or ite	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 December 2 □ No If Yes, Give Year or Dates:		/	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, Thite, etc. BLACK
21212-6	ed within 72 he	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give ki	nt's Usual Occupa nd of work done di NOT use retired) ABOR	uring most of wo	rking	STE	
yland	ould be file Mental Hy arked oth atic event	To Be		IMMS			18. Mother's Nar	ne (First, Middle, Maid DA	en Sumame)	
, Mary	and 2 sh ealth and m 27 is m			ams WIFE	703 (	CURLEY	nd Number or Ru			e, Zip Code) MD 21205
Baltimore,	permil. Peges 1 Department of H Importent: If Ites any injury or ott		20a. Method of Disposition  1 Burial 2 Cremation 3 Ci  4 Donation 5 Other (Specify  21. Signature of Funeral Service Licens	Removal from State	KKISON .	Name and Address	s of Facility V4	8.04 UWI	EENE FO	or Town, State U.S., MARYLAND DIEKAL HOME RYLAND 21212
8/60,	death certificate be executed  Physician  Parameter as the bural-transit  A for use as the bural-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect of the total or as a	uence/of):  Lif  juence of):  Levico	Eder Disease	M G.			Veaus Veaus
O. Box 6	w requires that the death certific been signed by the attending pi should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	ıl death 3⊟E	ctopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
ecords, P.	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions co	ontributing to death but not res	sulting in the und	erlying cause giver	n in Part I.	23e. Did tobacc	_	to the cause of death? Probably 4 Munknown
итаі жесс	The lay ate has page 2	e Completed	25. Was case referred to medical				Of Place of Dec	24a. Was an autopsy performed? 1 Yes 2 Yes	prior t death	autopsy findings available o completion of cause of es 200 No
	Physician: this certific ral director,	To B	eyaminer?	Hospital: 1 Inpatient 2 X	ER/Outpatient	3□ DOA Other		ome 5 Residence	6 □Other (Si	pecify)
lon or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,		27. Manner of Death 1 Shatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury Work M 1 \( \sup Y		28d. Describe how in		,
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stree y)	t, factory, office		28f. Location (Street City or Town, Sta	and Number or ite)	Rural Route Number,
	he Hospi in 24 hou the Funer pletely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno iner. On the basis of examina and manner stated.	owledge, death outline and/or inve	occurred at the time stigation, in my opi	e, date and place inion, death occu	, and due to the cause rred at the time, date a	(s) and manner nd place, and d	as stated. ue to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	La Mo		29c. License	number 0354		Pate signed (Mo	
	10		30. Name and address of person who c	LIANG MY		int) JOHA	worth	cins litery-	ted BAUTIMO	ne, ND 21287
	Sta		31. Date filed (Month, Day Year)	200 /32. Regist?er's Signa	ature 12	mark)				

			1 - For State	State of Maryland		ment of Hea				2004	07301
			Registrar  1. Decedent's Name (First, Middle, Last,	)		rease or be	Jan	2. Date of Death	1	-009	3. Time of Death
	hysici /Medic		LEONARD	DORSEY	Wi	LLIAM?	3	March	Day	7 2 004	1 4:35 A M
	Examin		4a. Fecility Name (If not institution, give	street and number)	4	b. City, Town, or Lo				county of Death	
			0000	an Hospit	al		nore			NA	
	ineral rector		210	7. Age (In yrs. le			Hours Min.	8. Date of Birth (Month, Day, OCTOBER	Year)	Cou	plece (State or Foreign ntry)
land	MO II		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Locat	ion					10d. Inside City Limits
Mary	flects	tor	MARYLAND	B	ALTIM	ORE		-			1⊠Yes 2□No
th the	or 28e e not	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citize	en of What Cou	ntry?
uth wi	23a	rai	3508 GLENAR	MAVENUE		21200	0		US	SA	
er dez	tems	nue		12. Was Decedent Ever in U.S Armed Forces?	6. 13. Wa:	Decedent of Hispa es, specify Cuban, h	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	Race - Ameri Black, White,	
rs aft	or a	by F	1 ☐ Never Married 2/5 Married 3 ☐ Widowed 4 ☐ Divorced	1 Des 2 □ No If Yes, Give Year or Dates: WW	10	Yes 2 ANO S	Specify:		s	pecity: \/	HITE
at y failtig Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	etura cal E		15. Decedent's Edu	cation	16a. Deceden	's Usual Occupatio	n	1	6b. Kind	t of Business/In	
thin 7	an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind	d of work done duri NOT use retired)	ng most of work	ing			C
yiaila z 12 ould be filed with Mental Hygiene.	her th	Con	12		SAL	ES			ET	HLEHE	NSTEEL
be fi	sveri	Be	17. Father's Name (First, Middle, Last)			18	. Mother's Name	e (First, Middle, M	aiden Si	umame)	
hould d Mer	nark	오	WILLIAM W  19a. Informant's Name/Relationship (Ty		10h Mailine A	ddrann /Strant and	1 KEN	E PAI	RK.	<u> </u>	- 0 - 4 - 1
d 2 should be and lith and	ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic svent, the Medical Examiner must be notified at 8.		NANCY WANNER	DIVENTES	South Control	ddress (Street and	IA SI DINA	I Noute Number,	City or i	own, State, Zif	1000
s 1 and f Health	other		20a. Method of Disposition	1 60	ace of Disposition	on (Name of	ALL KON	Date 2	0c. Loca	ation - City or To	own, State
permit. Pages Department of the	nt: H ry or	i	1)X Burial 2 ☐ Cremation 3 ☐ P  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ANEY	ory or other place)	Sillie	H 11, 2004 "	I IIa A	ACA VIA PA	TLA A
Dallilli permit. Pag Department	porta y inju		21. Signature of Funeral Service Licens		The same of the sa	ame and Address o	Facility	VANS CH	AAPE	EL OF	MEMORIES
<u> </u>	sny ir		And the second s		5 880	D HARA	FORDRO	PARK	VILL	E, MD	21234
	13)		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not enter ti	ne mode of dying, s	uch as cardiac	or respiratory arre	st,		Approximate Interval Between
	sician		Immediate Cause (Final disease or condition resulting in death)	SEPSIS							Onset and Death
	edical miner		resulting in death)	Due to (or as a conseque	ence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):						
petr	ansit	Examiner	Cause (Disease or injury	,	,						
be executed	an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
ite be ex	hysician and he burial-transit	icai		l							
orifica Orifica	After this certificate has been signed by the attending ph funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE:							<u> </u>	
a ta	ttend or use	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal o	death 3□Ect	opic pregnancy			230	d. Date of delive	ery Day Year
. e	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5 □ Ot	her (specify)				WOTH	Day Foai
that	ed by detac		Part II. Other significant conditions con	stributing to death but not resul	ting in the under	lying cause given in	n Part I.	23e. Did toba	icco use	contribute to the	ne cause of death?
D Sering	n sign	Completed by	Parkinsons					1 ☐ Yes	2 🗆 1	No 3 ☐ Prob	pably 4 Sunknown
5 ĕ	s bee	olete						24a. Was an		24b. Were auto	psy findings available
The la	ite ha	шо						autopsy perform 1 ☐ Yes 2	ed?	prior to condeath?	mpletion of cause of
1 mg	ctor, p	BeC	25. Was case referred to medical examiner?			26	. Place of Death	Check on one		1 🗆 165	2010
hysic	his ce il dire	To.	1 ☐ Yes 2 ☐ Xo	lospital: 1 hpatient 2 E	R/Outpatient :	B DOA Other:	4 Nursing Ho	me 5 Residen	ce 6 [	Other (Specify	γ)
a Bu	After t	iuo!	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how	injury o	occurred	
tend	tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon			2 No	704 Logation /Ctu		V	10 to North
lor A	Direc In by	Certification:	4 Homicide determined	building, etc. (Specify)	10, 141111, 511991,	ractory, office		28f. Location (Stre City or Town,		vumber or mura	I Moute Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my know her: On the basis of examination	ledge, death oc on and/or invest	curred at the time, o	date and place, a	and due to the cau	ise(s) an	nd manner as st ace, and due to	ated.  the cause(s)
o the	o the	Mec	29b. Signature and title of certifi-	and manner stated.		29c. License nu				signed (Month,	
<b>⊢</b> 3 :	⊢ ა '		Mali	(Musin Partel	141 10	Reso					*
23	$\Delta$		30. Name and address of purson who co	mpleted cause of death (Item :	23a) (Type. Prin		1001	11/	ur	CV1-1,2	007
54			Nilesh Patel	MD 5601	Loch	Equen B	lud, G	a I time	10 1	VD 8	1004
F	Sta Registr		31. Date filed (Month, Pay, Year) MAR 1 0 2004	32. Registrar's Signatu	Ano	. V. 1	•		,		

DHMH 17 Rev 1/2001

Leonard Williams

		_1	For State Registrar	State of Man	yland / De <i>C</i>	epartment of H Certificate of I	lealth and M <i>Death</i>	lental Hygien ۱۹ Reg. ۱	+	07305
	siciar edica	١	1. Decedent's Name (First, Middle, Last)	M	ARIE	WAY	1	2. Date of Death Month B	2004	3. Time of Death 10.15 PM
	mine ral	r	213.03.2333	118 HOS	PICE n yrs. last birtho 84 Yrs	Timon  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea APRIL 1		ORE place (State or Foreign orty)  RYLAND
e Maryland ta-f ehow	100		Usual Residence of Decedent  10a. State  10b. County  MARYLAND  BALTIM		Oc. City, Town o				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with the 23a or 28	Circuit Livering	al Die	10e. Street and Number 305 E. JOPPA	ROAD, A			360		Sitizen of What Cour	ntry?
5-0036 72 hours after death with the Maryland natural', or items 23s or 28s-1 show their Earth ser multipled at	hv E	2	11. Maritat Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	or in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛱 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
V1215-0036 within 72 hours at ene. then "natural", or	patalamo	palalding	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	1 (0	ecedent's Usual Occup. Give kind of work done of e. DO NOT use retired	durina most of worki	ng 16b.	Kind of Business/In	dustry UCATION
Maryland 212 d 2 should be filed withi th and Mental Hygiene. i? Is marked ofter than traumatic event.	9 0	מ	17. Father's Name (First, Middle, Last)  CHARLES H.	VEUMAI	111	4100 1011		(First, Middle, Maide	- 910 - 2	
Te, 1 an Heal		4	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	OWE DAVO	175R 38	alling Address (Street a BIS THOR Isposition (Name of crematory or other place	OVEHERE.	Date 20c.	To Town, State, Zip	S, MD
Baltimore, permit. Pages 1 a Department of Hea Importent: If item any injury or othe	- BOUCE		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		CHAP	22. Name and Address PEACEFUL	- ALTERN		NERALACR	EMATION CTA 21093
Physici /Medic Examin	eal er	5	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	LUNG CA  Due to (or as a c	NCER onsequence of):					Approximate Interval Between Onset and Death
68760, fitcate be executed physician and st the burial-transit	Evaminar	LYD	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
Hecords, P.O. Box 68 The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as the	lan/Ma	iysicidiii/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
COLCS, P. wrequires that been signed b	2	Š	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in th	e underlying cause give	en in Part I.		use contribute to the	ably 4 🛣 Unknown
	, ,							24a. Was an autopsy performed?	death?	psy findings available inpletion of cause of
Of V Physic r this ce	5	2	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending	lospital: 1  Inpatient 28a. Date of Injury (Month, Day Yo	2 ☐ ER/Outpa 28b. Tim ear) Inju	e of 28c. Injury	/ at /?	ne 5 Residence 28d. Describe how inj		HOSPICE
ivision  or Attenter deat ter deat irector:	riffo	ver unican	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm Specify)	M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No	28f. Location (Street a City or Town, Sta		I Route Number,
To the Hospitel or within 24 hours at To the Funerel D completely filled is	Madical	- Calca	(Check only 2 Medical Examination)	sician: To the best of mer: On the basis of example and manner stated	amination and/o	eath occurred at the tim r investigation, in my op	pinion, death occurre	ed at the time, date ar	nd place, and due to	the cause(s)
			29b. Signature and title of certifier	2~			3725	29d. D	ARCH 9,	2004 2004
6			30. Name and address of person who co  DR. TARIQ MAHMOO  31. Date filed (Month, Day, Year)		LANEY V	pe, Print) ALLEY RD.	TIMONIUM,	MD 21093		···
	State istrar	2	MAR 1 0 2004	32. Hegistrars	Signature	Aports!				

DHMH 17 Rev 1/2001

10:15 p.m.

MARCH 8, 2004

ALMA WAY

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 Month Yeer **Physician** March 6, 4:12 F. Whitmer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABaltimore Johns Hopkins Bayview Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** September 27, 1928 1**X** M 2□ F 75 Director 212-26-1258 MD Usuel Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits other than "natural", or items 23s or 28s-f show vent, its Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Dundalk MD Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 8109 Dundalk Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yardman Transportation/Auto 12 years es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie I item 27 is marked other I rothar traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mamie Arnold 0 Lory Whitmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : Mary Whitmer wife 8109 Dundalk Avenue, Dundalk, Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Pages March 9, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō permit. Page Department o Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Baltimore City, MD. Bayview Crematory 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due-to (or as a consequence of): Examiner man Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Striknown Be Completed extension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 HT OA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles 5 101 31. Date filed (Marit) (Pey, Year) Registrar's Signature State Registrar

Earon W 04-1404 **AKG** 

> Phy Ex

Fun Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show

**Physic** /Medi Exami

Baltimore, Maryland 21215-0036

1. Decedent's Nam	111 1011/25	State of A b,27,PerME	, 300,4/1/	Certi	ficate of	Death		Reg. N	10. ZUI	04	0/30
- Earmo		st) Earon W.		liama	_		2. Date of D Month	D		'ear	3. Time of Dear
I Garilla Name		re street and number				or Location of D	Febru		23, 20 c. County of	004	2:40 I
	h Street	e street and number	,				eatn		•		
5. Social Security I	lumber 6. S	Sex 7. A	ge (In yrs. last b	pirthday)	ilver S If Under 1 Year Months Days	If Under 24	B. Date of B. (Month, D	irth av. Yea	r)	Birthp	lace (State or For
Usual Residence of	f Decedent						100.1	0,1	J J J T		
10a. State	10b. County		10c. City, To		tion					1	0d. Inside City Lin
2	Montg.		Rockv	ттте	10/ 71 0 /						¹X Yes 2□
10e. Street and Nu		Ctools			10f. Zip Code 20853	•			itizen of Wh	at Cour	itry?
14012 C	akvale	12. Was Deceden	Fyer in U.S.	13 Wa			? (Specify Yes or N		USA 14. Race -	Amoria	na ladina
3	ied 2 Married	Armed Forces  1 7 Yes 2 1	?	If Y	es, specify Cut	oan, Mexican, P	uerto Rican, etc.)	0-		White,	etc.
	15. Decedent's E	Year or Dates	1 16:		nt's Usual Occu			105			
	cify only highest gra	ade completed)		(Give kın	id of work done NOT use retire	during most of	working	160.	Kind of Busir	ness/ind	Justry
Elementary/Sec 12t		College (1-4or	·	lecti	rician	, 		м	ilita	2737	
	(First, Middle, Last,	)		1000	LICIAN		Name (First, Middle			<u> y</u>	
Samuel	Si	mmons				Geral	dine Wi	11i	ams		
19a. Informant's N	ame/Relationship (	Type, Print)	19	b. Mailing A	Address (Stree	t and Number o	r Rural Route Numb	er, City	or Town, Sta	ate, Zip	<sup>Code)</sup> 152
Earon R	. Willia	ams (Son	) 4:	20 F1	t.Duqu	esne E	31vd.#16	00,	Pitts	bui	g pa
20a. Method of Dis		7-	20b. Place	of Disposition	on (Name of ory or other pla		Date		ocation · Cit		
	☐ Cremation 3 ☐ 5 ☐ Other (Specif	]Removal from State fy)				Čem¦3/	15/04	Ar	lingt	on,	,Va.
21. Signature of F	ineral Service Licer	nsee		22. N	ame and Addre	ess of Facility	Tri-Sta				
sim	a Elan	ral		913	2 Thir	9 C+ V	W. Wash		the formation of the same		
a. Part1. Enter	he discuse, or com	plications that cause one cause on each	d the death. Do	-					C. Z.00		Approximate
Immediate Cause	(Final		s of the l	Liver							Onset and Death
resulting in death)	n	a	a consequence								
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Sequentially list co	imediate 👚	b. —	a consequer of								
	injury										
cause. Enter Under Cause (Disease or		C.								-	
cause. Enter Unde Cause (Disease or that initiated event resulting in death)		Due to (or as	a consequence	of):							
cause. Enter Under Cause (Disease or that initiated event resulting in death)		Due to (or as	a consequence	of):							
cause. Enter Unde Cause (Disease or that initiated event resulting in death)		Due to (or as	s a consequence	of):							
cause. Enter Under Cause (Disease or that initiated event resulting in death)	Last	d	of pregnancy						23d Date o	f delive	N.
cause. Enter Under Cause (Disease or that initiated event resulting in death)	t pregnant months?	_d	of pregnancy	h 3⊡Ec	topic pregnanc	у			23d. Date o		ry Day Year
cause. Enter Under Cause (Disease or that initiated event resulting in death)	t pregnant months?	_d	of pregnancy	h 3⊡Ec	topic pregnanc	у					,
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cause. Enter Under Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknowr  Part II. Other signi	t pregnant months?	23c. If yes, outcome 1	e of pregnancy 2	h 3 Ecc 5 Oi	ther (specify) _	ven in Part I.  26. Place of (	24a. Was auto perfo	an psy primed? 2 \( \text{No.000} \)	Month use contribut l No 3[ 24b. Wer prior deal	Probate to the Probate to control of the Probate to control of the Probate to Control of the Probate to Control of the Probate to Control of the Probate to	Day Year  e cause of death?  ably 4 Punknot  sy findings availa  pletion of cause  2 No
cause. Enter Under Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	t pregnant months?  No  red to medical	23c. If yes, outcome 1  Live birth 4 Pregnant a 9 Unknown	e of pregnancy 2 Fetal death at time of death but not resulting	h 3 Ecc 5 Oi	ther (specify) _	ven in Part I.  26. Place of I	1 □ 24a. Was auto perfo	an psy primed? 2 □ No	Month use contribut Use contribut Co	Probate to the Probate to control of the Probate to control of the Probate to Control of the Probate to Control of the Probate to Control of the Probate to	Day Year  e cause of death  ably 4 Munknot  sy findings availation of cause  2 No

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

**Medical Certiflcat** 

State Registrar

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Commonship Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

February 24, 2004

30. Name and d cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) MAR 1 0 2004

3 Suicide
4 Homicide

29b. Signature and title

29a. Certifier

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H tificate of L	ealth and Death	Mental Hy	giene Reg. No.	2004	07308
	Physicia		1. Decedent's Name (First, Middle, Last) Flore	ence G. W	Jassmer			2. Date of De Month March	Day	Year 04	3. Time of Death 10:35 A M
ţ.	/Medic Examin Funeral	er	4e. Facility Name (If not institution, give s Manor Care Potomac 5. Social Security Number 6. Sex	2	yrs. last birthday)	4b. City, Town, or Potoma If Under 1 Year Months Days		8. Date of Bir	th	County of Dealh  Iontgome  9. Birthp	Ty  place (State or Foreign
	Director	tor	018-14-9045	10	c. City, Town or Lo			April 2	22, 19		achusetts  10d. Inside City Limils  1□Yes 2됬No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Itema 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	TT. Warker States	2. Was Decedent Eve Armed Forces?	r in U.S. 13. \	10f. Zip Code  208  Was Decedent of Hif Yes, specify Cuba		Specify Yes or No to Rican, etc.)	Unit	en of What Cour ed Stat 4. Race - Americ Black, White,	es can Indian,
15-0036	in 72 hours afte n "natural", or l	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	completed)	16a. Decec	1 ☐ Yes 2 ☑ No  dent's Usual Occupa kind of work done of DO NOT use retired	turina most of wo	rking		Specify: Whi	
Maryland 21215-0036	d be filed withi antal Hygiene. ced other ther c event, the M	To Be Comp	17. Father's Name (First, Middle, Last) Frank C. Hinckley	College (1-4or 5+) 4	Home	emaker		me (First, Middle	, Maiden S		
re, Maryl	1 and 2 shoul Health and Me Iem 27 is merl	Ė	19a. Informant's Name/Relationship (Tyx) Grace E. Holt / Da 20a. Method of Disposition	oe, Print) Bughter	12604	ng Address (Street a Orchard sition (Name of natory or other place	Brook Te		Poton	·	yland 20854
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Ri  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	emoval from State	Iontgomery C	rematorium,	Inc. 200	)4 eral Home/	Bethes	esda, Ma	Chase, Inc.
	Physician /Medical Examiner		23a. Pert1. Zoler the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulling in death)	cations that caused the e cause on each line.	of Alzh		g, such as cardia				Approximate Interval Between Onset and Death Years
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, heading to amediate cause. Enter Underlying Cause, Disease or injury that indiated events resulting in death) Last	Due to (or as a co							
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ery Day Year
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.				ne cause of death?
tal Reco	in: The law r ificate has be or, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Do	24a. Was auto pento 1 Yes	psy ormed? 2 No	24b. Were auto prior to condeath? 1  Yes	psy findings available mpletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	examiner?  1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpalient 28a. Date of Injury (Month, Day Ye	2 EP/Outpatien 28b. Time of Injury	28c. Injury Work	or: 4 Nursing H		dence 6	Other (Specify occurred	y)
Divis	To the Hospitel or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune	ai Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)  y knowledge, death	n occurred at the tim	ne, date and place	City or To	wn, State) cause(s) a	Number or Rura	tated.
)	- /	Medical	(Check only 2   Medical Examir	ter: On the basis of example and manner stated	amination and/or in	vestigation, in my or	oinion, death occi	urred at the time,	date and page 29d. Date	place, and due to signed <i>(Month,</i> h 9, 200	Day, Year)
	18		30. Name and address of person who co	. 11125 Ro	ckville l	Print) Pike, #20	8, Rockv	ille, Ma	aryla	nd 20852	2
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's		Spark	,				

			4 101	partment of Health and Mertificate of Death	lental Hygie	ene 200!	07309
			Decedent's Name (First, Middle, Last)	oranoate or beating	2. Date of Death		3. Time of Death
	Physici /Medio		QUEEN E. WILLIAMS		MARCH 6,	2004 Year	2:15p M
1	Examin	er	4a. Facility Name (If not institution, give street and number) 709 LYNDHURST ST.	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth		place (State or Foreign
	Director		217-22-5804 1□M 2∏F 89 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 8-27-191	(ear) Cou	place (State or Foreign ntry) GINIA
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryl.	tor	MD. N/A BALTIM				14 Yes 2 □ No
	or 28e	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	ath wil	<b>Funeral Director</b>	709 LYNDHURST ST.	21229		USA	
	iteme	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
920	urs af	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give △ → Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLA	ACK
20	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28e-f show ont, the Medical Examination culfilled at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	pedent's Usual Occupation we kind of work done during most of work	ng 16	b. Kind of Business/Ir	ndustry
121	within ene. than	mp	Elementary/Secondary (0-12) College (1-4or 5+)	SUPERVISOR		RENTEX	
<b>d</b> 2	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Last)		(First, Middle, Ma.		
/lan	uld be Mental irked o	To Be	JOHN W. ROSE	ROSSIE	SHANDS		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28e-f show or other treumatic event, tre Madical Examiner must be notified at			iling Address (Street and Number or Rura			
	1 and Health em 27 Ither t		ELLENOR SMITH(DAUGHTER) 520  20a. Method of Disposition 20b. Place of Dis	6 HILLWELL RD. BALT		ARYLAND 21 c. Location - City or To	
nor	ages ant of nt: If it y or o				1-2004	•	, MARYLAND
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21. Signatur Funeral Service Licensed JONATHAN D. HIBNE	f k . Name and Address of Facility $ m PHII$	LIPS FUN	ERAL HOME,	P.A.
8	99 5 8			721-27 N. MONROE ST			AND 21217
			23a. Pant Enter the disease, or complications that caused the death. Do not a shoot, or heart failure. List only one cause on each line.	inter the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. <u>GASTRIC OUTLET</u>	OBSTRUCTION			
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  Due to (or as a consequence of):  PERIAMPULLARY N	EODI ACTA			
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	EUFLASIA			
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
760,	icate be executed physician and s the burial-transit	cal E	d d				
89		-					
Вох	ath cer ttendir or use	an/N		□Ectopic pregnancy		23d. Date of delive	ory Day Year
P.O.	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 ☐No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Wichter	Day
	s that the ned by a detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
rds	w requires to been signer should be	ed b	HYPERTROPHIC CARDIOMYOPATHY		1 Tes	2 No 3 Prob	eably 4XXUnknown
900	law re	Completed			24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
Vital Records,	Physicien: The lav this certificate has ral director, page 2				performed		2 <b>X</b> No
	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🛣 No	26. Place of Death		e 6 ⊡Other (Specifi	
o			27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	8d. Describe how i		/)
sior	Attending r death. sctor: After by the funer	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	- 0 // -	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	8f. Location (Stree City or Town, S	t and Number or Rura Itate)	l Route Number,
	spitel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	ind due to the caus	e(s) and manner as st	ated.
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To To Com	Σ	29b. Signature that title of certifier  Hes/s III MO MOH	29c. License number		Date signed (Month, RCH 9, 200	
	2		This will be	D46334	TIA	THOIL 3, 200	J' <del>1</del>
	ט		PATRICK I. OKOLO, III MD. 2435 W.		TIMORE. M	IARYLAND 21	215
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	, , ,		
	Registra	ar	MAR 1 0 2004	ports			

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month YUTCHISCHE N STEVEN 213 PM 2004 4b. City, Town, or Locetion of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death ROAD FALLSTON HARFORD If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 MM 2□ F 10 Pennsylvania 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: W W ☐ 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) AIR 8,2004 22. Name and Address of Facility EVAN'S FUNLER 21. Signature of Funeral Service/Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mocard Due to (or as a consequence of): 011 Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown None 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 1152 Yes 2 □ No Hospital: 0

by Physician/Medical Examiner led by the attending physician and datached for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

by Funeral Director

Completed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

f Haalth and Mantal Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Macilian Examinar must be notified at

Dapartment of Haalth and Mantal Hygi Important: If item 27 is marked other

Physician /Medical

Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be axecuted

After this certificate has been signed funeral director, page 2 should be da

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

after death.

Medical Certification; To Be Completed

1 Natural

2 Accident

3 Suicide

4 I Homicide

Division of Vital Records, P.O. Box 68760,

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part
The second secon

101.01			Describe how ini	
ther:	4 ☐ Nursing H	ome	5 X Residence	6 □Other (Specify,
	O. Place Of Dea	IIII (C	neck only one)	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2004

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10014206 MI

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) PLABIRD AVE BERNARD MD, DME 31. Date filed (Month, Day, Year)

State Registrar

MAR 1 0 2004

32. Registrar's Signature

Please	Type or	Print	in	Black	Indelible	lnk.	Ensure	All	Copies	Are	Legible

Carol Morgan	o .	Yates	Please	Type or Prin						_	
04 <b>-1</b> 561 AKG		1 = For Unper	nd Item#23a	State of Ma <b>Per ME,G</b> 3,	aryland / D <b>329,3/22/0</b> 4	epartr <b>Sertifi</b>	ment of H icate of i	lealth and M <i>Death</i>		giene 200	07311
Physicia			e (First, Middle, La		·	ates			2. Date of Dea Month		3. Time of Death 4 5:40 P M
/Medica		4a. Fecility Name (	If not institution, giv	e street and number)		4b	. City, Town, o	r Location of Death	1101	4c. County of Dee	
J. 18	Ŷ,	2322 Ma	ytime Dri	ive		(	Gambril	ls		Anne Aru	ndel
Funeral		5. Social Security N	lumber 6. S		e (In yrs. last birti	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 1	Year) 105 9. Bi	thplace (State or Foreign ountry) irginia
Director		224-68-	3037		49	rs.			Sept. 1	3, 1954	rginia
/land		10a. State	10b. County		10c. City, Town	or Location	on				10d. Inside City Limits
e-f sh	cto	MD	Anne A	runde1	Gambi	rills					1 Tes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner count be multified at once.	Director	10e. Street and Nu				1	Of. Zip Code		1	log. Citizen of What C	ountry?
ns 23e	era	11. Marital Status	ytime Dr.	12. Was Decedent	Ever in ILS	13 Was	2105		orify Yes or No-	USA 14. Race - Am	erican Indian
fter d	Funeral		ried 2 XMarned	Armed Forces?				dispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Whi	
036 ours a	þ	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:		1 📙	Yes 2X∏ No	Specify:		Specify: W	Thite
5-0 72 ho 72 ho	etec	(Spe	15. Decedent's E cify only highest gra	ducation ade completed)	16a.	Decedent' (Give kind	s Usual Occup of work done	pation during most of worki d)	ng	16b. Kind of Business	/Industry
Within within than the Man	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)		w <i>or use retired</i> maker	a)		Own Ho	me
d 2 filed Hygir ent, m		17. Father's Name	(First, Middle, Last					18. Mother's Name	(First, Middle,		
lan lid be lental rked c	To Be	James Ed	dward Mor	gan				Emily Ea	ıkle		
and N	1			•	band) 19b.	Mailing A	ddress (Street	and Number or Rura	il Route Number	r, City or Town, State,	Zip Code)
and and and martra			George Ya	tes III	losi Bi (			ne Drive G			
Baltimore, Maryland 21215-0036 sernit. Pages I and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural; or any injury or other traumatic event, the Medical Examples.			Cremation 3	Removal from State		y, cremato	ry or other plac	ce)		20c. Location - City or	
ftir it. Pa intmer intmer injury			5 Other (Special Control of the Cont		Inorni	-	Cemeter	1		Staunton,	VA
Bal permi Depa Impo Impo		Xa	10, 1	Last 1	1001	Ha:	mrick F	ss of Facility Funeral Ho	me	ton, VA 24	201
AND REAL PROPERTY.		23a. Paril. Enter	the disease, in the	plications that caused one cause on each li	the death. Do n						Approximate Interval Between
Physician	9	mmediate C se disease or conditi	-			rioscle	emotic Ca	rdiovascula	r Disyaco		Onset and Death
/Medical Examiner		resulting in death)	(		a consequence of		a ocac ca	a di Ordicana	Macrae		
**	_	Sequentially list co	onditions,	b. Sain to for the	a sunsequence o	n.					
nsit	Examlner	cause. Enter Und Cause (Disease of	erlying r injury	200 10 (01 42	a delle oquello e						
'60, be executed sician and burial-transit	Exai	that initiated event resulting in death)	Last	Due to (or as	a consequence of	of):					
760, ate be ex sysician he burial	ca		- (	d							
Division of Vital Records, P.O. Box 6876 to a Attending Physician: The law requires that the death certificate be after death.  Director: Atter this certificate has been signed by the attending physic bin by the funeral director, page 2 should be detached for use as the bin by the funeral director, page 2 should be detached for use as the bin by the funeral director.	by Physiclan/Medlo	IF FEMALE:		00-16	-1						-
Boy eath co	lan/	23b. Was deceder in the past 12	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death		opic pregnancy her (specify)	4		23d. Date of de Month	livery Day Year
P.O. BC	ysic	1 ☐ Yes 2 9 ☐ Unknow		9□ Unknown	t time or death	J   Oli	isi (specify)				
S, P	y P	Part II. Dther signi	ificant conditions	contributing to death b	out not resulting in	the under	tying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
cords w require been sig	edt								1 🗆 Yı	es 2□No 3□P	robabiy 4 []Unknown
ecc law re as be	plet								24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Vital Re(incian: The lavecertificate has	Completed								1 perform	med? death? 2 No XYe	
Vita nician certific rector,	Be	25. Was case refe examiner?		Hospital:			Oth	26. Place of Death			A+ ggoso
Physic this oral dil	1: To	1 X Yes 2 ☐ 27. Manner of Dea		28a. Date of Inju		ime of	28c. Injur	4 🗆 Nuising mo		ence 6 <b>OOther</b> (Specow injury occurred	ecify) At scene
ion nding ath. r: Afte e fune	atlor	1 Natural 2 ☐ Accident	5 Pending investigation	( <i>Month, D</i> a in	y Year) Ir	njury		rk? Yes 2 □ No			
ViS r Atte recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	200. Flace of Inj	jury · At home, fai	rm, street,	factory, office		28f. Location (Si City or Town	treet and Number or A n, State)	ural Route Number,
Diffet or urs aft rel Diffed in led in										-1.00.048	
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2823 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and	, death oca d/or investi	curred at the tir igation, in my o	me, date and place, a ppinion, death occurr	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
o the o the o the omple	Mec	29b. Signature Inc	d title of certifien	and manner so	a160.		29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year)
F 3 F 8			Linke	(M)			O.C.M	.E.	N	March 2, 20	004
_		30. Name and add	irys of person who	completed cause of	eath (Item 23a) (	Туре, Prin	t)				
		U.UA	far u	cre M	)		111 Per	nn Street	, Baltin	nore, Mary	Land 21201
Stat Registra		31. Date filed (Mo		32. Registr	rar's Signature	Kn	reks				
riegistre		MAR	1 0 2004	The state of the s	14	popul	-69618				

			State of Maryland / Department of Health and Mental Hygiene 2004 07312
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle Last)  Chery Roan Black  2. Date of Death Month Day Year 0935— A  La Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 DF 7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Months Days Hours Min.  Nov. 17, 1952 Maryland  Maryland
	he Maryland 28e-f show ctiffed at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Kent Chestertown 10c. Street and Number 10t. Zip Code 10c. Citizen of What Country?
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Indocther then "natural", or Items 23a or 28e-1 show event, I're Medical Exerciting to usal be ristilied at	by Funerai Dir	23169 Baywood Ct.  21620  USA  11. Marital Status  1
Maryland 21215-0036	e filed within 72 houn al Hygiene. i other then "natural vent, Ine Modical E.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 11    College (1-4or 5+)   Housekeeper   Housekeeper
larylanc	should and Mer s marke numatic	To Be	John Wellington Goldsbourgh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, N	permit. Pages 1 and 2 Department of Health i Important: If item 27 I any injury or other tra		Danielle Black / Daughter 23169 Baywood Ct., Chestertown Maryland21620  20a. Method of Disposition  1. Burial 2 Cremation 3 Removal from State  1. Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  3 Removal from State  3 Date 20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State
<b>Balti</b>	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Bennie Smith Funeral home Road 298, Chestertown, Maryland 21620  23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):
8760,	cate be executed  physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):
.O. Box 6	death certifii e attending p id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Vital Records, P	law requires as been sign 2 should be	Completed by P	Part   Other significant conditions contributing to death but not resulting in the underlying cause given in Part      Compared   Co
Vital R	Physician: The this certificate har all director, page	Be	25. Was case referry to medical examiner?  26. Place of Death (Check only one)
Division of	Attending Physic death. sctor: After this opy the funeral dir	Certification: To	27. Man er of Death Natural 5 Pending 1 Inhpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury Natural 5 Pending 2 Accident investigation 2 No. Natural 5 Pending 1 Inhpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Work? M 1 Yes 2 No.
Divi	To the Hospitel or Attending Phywithin 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral of		4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the H within 24 To the Fi complete	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of Centifier  29c. License number  29d. Date signed (Month, Day, Year)
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta Registr		Andrew S. Ferguson MD 120 Specy KD SucteII Chestertown MD 21120  32. Registrar's Signature  FEB 25 2004  Andrew  Andrew  Andrew  FEB 25 2004

State of Maryland / Department of Health and Mental Hygiene 2001 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 24, Mildred R. Burdette February 2004 8:05a /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Lorien Nursing Home Mt. Airy Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□M 213 F Director July 12,1909 220-56-1832 94 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or thems 23s or 28s-f show sny injury or other traumatic event, the Marical Examiner must be not lifted at once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 713 Midway Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. þ 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ira W. Beauchamp Irene H. Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney B. Burdette Jr./Son 236 Oarlock Circle, East Syracuse, New York 13057 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar Springs Cemetery 2/28/04 Mt. Airy, Maryland 21. Signature of Emeral Service Licensee Olin L. Molesworth P. A. Funeral Home odel 126401 Kidge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADBTIC EARS disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The faw requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): attending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown is signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autoosy performed certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No 2 1 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeref 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D26499 February 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, MD #4 Culwell Drive, Mt. Airy, Maryland 2177 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Annal Registrar

OF.

ORIGINAL

DHMH 17 Rev 1/2001

FEB 2 6 2004

State of Maryland / Department of Health and Mental Hygiene 2004 073 11

				Otato or ma	, y laria,	Cert	ificate of	Death	R	eg. No.	UH	0/3/4
			1. Decedent's Name (First, Middle, Last	1)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al l	Ida Mae Brown						Februar	y 19, 20	004	3:55 p.m.
	Examin	10	4a Facility Name (If not institution, give Northampton Manor					4b.City,Town,orL Frederick		Frede	of Death rick	
ì	Funeral Director		220-26-0014	7. Age ☐ M 2区 F 8	(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 1,	Year)	9. Birthple Count Mary1	ece (State or Foreign ry) and
-	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation				10	d. Inside City Limits
	Menyle f sho	6		ck	Fre	deric	k					1GAYes 2□No
	or 28e	Direct	Maryland Frederi  10e. Street and Number  368 Madison Street				10f. Zip Code 21701			10g. Citizen of W		ry?
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel; or items 23a or 28e-f show simportant: if item 27 is merked other than "naturel; or items 23a or 28e-f show simply injury or other treumsitic event, the Medical Examinar must be inclined at once.	by Funeral Director	11. Marital Status  1 Never Married 3 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			las Decedent of I Yes, specify Cub ☐ Yes 2424No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black	e - America k, White, e blac	etc.
9	2 hour	ted b	15. Decedent's Ed	ucation	10	6a. Decede	ent's Usual Occu	pation during most of work	kina	16b. Kind of Bu	siness/Ind	ustry
21	ithin 7	mpie	(Specify only highest grad	College (1-4or 5				during most of work ad)		own	home	2
2	led w tygier her th	S	7 17. Father's Name (First, Middle, Last)		E	lomema	iker	18. Mother's Nam	ne (First, Middle,			
<u>land</u>	uld be fi fental H ked ot fic ever	To Be Completed	Harry Snowden						Bowie			
Maryland 21215-0020	d 2 shouth and N is man		19a. Informant's Name/Relationship (T Luther O. Brown,			9b. Mailing 368 1	g Address <i>(Stree</i> Madison	tand Number or Ru Street, F	ral Route Numbe Tredericl	r, City or Town, k, Maryl	State, Zip .and 2	Code) 21 <b>7</b> 01
Baltimore,	es 1 an of Heal fitem 2 r other		20a. Method of Disposition  1   Burial 2   □ Cremation 3   □		20b. Place ceme	etery, crem	ition (Name of atory or other pla		Date	20c. Location -		
Ĕ	Pag Iment bant: }		4 □ Donation 5 □ Other (Specify	)	Fair		Cemeter	J				, Maryland
Bal	Departimonal important in portant		21. Signature of Funeral Service Licen	1000	Thur		Name and Addr	s, Marylar	auffer 1 1621 0 nd 2170	runeral possumto 02	wn P	ike
25			23a. Part1. Enter the disease, or comp. shock, or heart failure. List only	plications that caused one cause on each lin	the death. I	o not ente	r the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final								n	
3	Examine		disease or condition resulting in death)	a	Due to (or as	a consequ	uence of):	ARBUT	2011		///	104/25 1/0000
	D #	iner		b. H.	9852	TENS	sive C	argnar	VASCU	canl	15	YEARS
,	tificate be executed g physician and as the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as	a consequ	uence of):				i	
68760,	tificete be execut ig physician and as the buriel-trar	licai	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as	a consequ	ence of):					
		Mec		d								
Bo	attenc for us	clan	Part II. Other significant conditions of	- stalle state to don't be	ut pot rocultin	a in the ur	derlying cause o	iven in Part I	23b. Did 1	tobacco use co	ntribute to	the cause of death?
P.O. Box	the d	Physician/M						Worth Later.		_		pabiy 4 🗆 Unknown
	es that gned be del	ьу Р	Dinon/n	) My Dec	-1791						24h W/	ere autopsy findings
Records,	law requires that the death cer as been signed by the attendir s 2 should be deteched for use	Completed by	DIAMATA ATRIAC DOMENT	FIBRIC	CAT	ON			24a. was perfo	an autopsy med?	ava	ailable prior to mpletion of cause death?
Re	2 55 8	ошо	DEMENT	TIA					10	Yes 2ДNo	1 [	Yes 2□ No
of Vital	ysicien: The la s certificate ha director, page	Be C	25. Was case referred to medical						ath (Check only o			
<u></u>	Physicien: rthis certific aral director,	일	examiner? 1 ☐ Yes 2 ☑ No		ent 2 ER			ther: 4 Nursing H				y)
o uo	ding Pi th. After the funera		27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	b. Time of Injury	28c. Inj W M 1[	uryat ork? ⊒Yes 2⊒No	28d. Describe	how injury occur	100	
Division	or Attending efter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not b determined	280. Place of In	ury - At home c. (Specify)	e, farm, str	eet, factory, office	э	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	al Route Number,
_	To the Hospital or Attending Phywithin 24 hours effer death. To the Funerel Director: After this completely filled in by the funeral	edicai C	29a. Certifier 1. Certifying Ph (Check only one)	ysician: To the best niner: On the basis o and manner st	f examination	dge, death and/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as s and due to	tated. the cause(s)
	ithin 2 o the	Med	29b. Signature and title of earth or	and mainer st			29c. Lice	nse number		29d. Date signe		
	F≯Fö		· Melle	le-	- M	-D.	0:	26499	7	2-1	19-	24
	Y		30. Name and address of person who Ronald Mille					, Mt. Air	y, Marvl	and 217	771	
		ate	31. Date filed (Month, Day Year)	32. Regist	s Signatur	0	1		, ,			·
	Regist	rar	1 20 %	J LUU4 P	The Care	J.	CARAGE	7				

			1- State of Marylan State of Marylan	d / Depa	rtment of H	ealth and N	Mental Hyg	iene 2004	07315
			Decedent's Name (First, Middle, Last)		unouto or E	Journ	2. Date of Deat	eg. No.	3. Time of Death
Н	Physici /Medio		George Dewey Beachley Jr.	,			Feb.	$2\overset{\text{Day}}{1}$ , $2\overset{\text{Year}}{0}$	10 A M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death	-1.
			Citizens Nursing Home			derick	T = -	Freder	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 80	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July	25, 1923 h	place (State or Foreign intry) MD
	and *		Usual Residence of Decedent     10a. State   10b. County   10c. Cit	y, Town or Loc	cation				10d, Inside City Limits
	Maryll	ţŏ	MD Washington		sville				1 Yes 2 □ No
	r 28e	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	th with	a D	2130 Boteler Rd.		217	58		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, I'te Medical Evantary in a frints be notified at 9008.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Never Married 2 Married  18. Was Decedent Ever in U. Armed Forces?  19. Was Decedent Ever in U. Armed Forces?  19. Was Decedent Ever in U. Armed Forces?  19. Was Decedent Ever in U. Armed Forces?  10. Was Decedent Ever in U. Armed Forces?  11. Was Decedent Ever in U. Armed Forces?  12. Was Decedent Ever in U. Armed Forces?  13. Was Decedent Ever in U. Armed Forces?  14. Was Decedent Ever in U. Armed Forces?	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: U	
21215-0036	2 hours	ted t	15. Decedent's Education	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Business/In	
212	hin 72 9. Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. [	kind of work done di OO NOT use retired)	uring most of work	ring		3301.9
	ed wit	Completed	6		mechani	С		auto	
and	be fill ntal H od ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			
Maryland	hould d Mer marke matic	은	George Dewey Beachley Sr.  19a. Informant's Name/Relationship (Type, Print)		a Address (Street a		lah E.	Markoe City or Town, State, Zip	Codel
Ma	ulth an 27 is r		Candiz Notnagle (Sister)	5404	01d nat	tional	Pike, F	rederick,	MD 2170
re,	s 1 au of Hea itam othe			lace of Dispos	sition (Name of natory or other place			20c. Location - City or To	
Ē	Page nent c				e's Cem		/04 F		e, MD
Baltimore,	permit. Departr Importe any inju		21. Signifure of Funeral Service Loansee	<b>1</b> 3	onald B.	Thomp	son Fun Middle	eral Home	21769
			23a Part1. Enter the disease, or complications that caused the death shock or heart failure. Vist only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	rent	Adenoc	nunm	na		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence)	uence of):					
	Zxammor	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	uance of):					
	nted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	rence or).					
Ć.	execuna and ial-tra	Exal	that initiated events resulting in death) Last C. Due to (or as a consequ	uence of):					
8760,	icate be executed physician and s the burial-transit	dical	d						
9		Med	IF FEMALE:						
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregna	death 3 🔲	Ectopic pregnancy			23d. Date of delive Month	ery Day Year
0	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	1 □ Yes 2 □ No 4 □ Pregnant at time of de 9 □ Unknown	∍ath 5□	Other (specify)			William	Day Feat
<u>α</u>	that t	Y Ph	Part II. Dther significant conditions contributing to death but not resu	ulting in the un	derlying cause giver	n in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
Vital Records,	quires n sign uld be						1 ☐ Ye	s 2X No 3□Prob	ably 4 Unknown
၀၁	aw requir is been si 2 should	Completed					24a. Was an		psy findings available
Ĕ	The lav ate has page 2	mo.					autopsy perform	ed? death?	inpletion of cause of
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			26. Place of Death		<del></del>	<b>X</b>
	Attanding Physician: sr death. actor: After this certific by the funeral director,	္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient		4 Nursing Ho		nce 6 Other (Specify	)
Division of	Jing Ph J. After th	lo	27. Manner of Ceath  1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at ° ? es 2 □No	28d. Describe hov	w injury occurred	
isi	l or Attandatter deat Diractor: in by the	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he	me, farm, stre			28f. Location (Str.	eet and Number or Rura	I Route Number
ă	al or A s after if Dirac	Certification;	4 Homicide determined building, etc. (Specify				City or Town,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Funeral Diractor: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	wledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and manner as st	ated.
	the H in 24 tha F nplete	fedical							
	To the within To the Comple	Σ	29b. Signature and title of pertifier	)	29c. License		29	d. Date signed (Month, I	Day, Year)
	0		1 my V admin	2021 ===		111		723/0	7
	1		30. Name and address of person who completed cause of death (Item	23a) (Type, P	'rınt)				
	Sta	te	31. Date filed (Month, Day, Year) 32, Registrar's Signat	ture	- <u>20</u> 121				
	Registr		FEB 2 6 2004	I Am					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day CHARLES **GARRETT** COOLEY 2004 4c. County of Death FEBRUARY 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 MM 2 □ F Director 216-30-0189 70 JULY 31 1933 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD MONTGOMERY Directo CLARKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14301 LEWISDALE ROAD or Items 23a 20871 USA 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: WHITE 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other then \*r Elementary/Secondary (0-12) College (1-4or 5+) 11 BUSINESS OWNER CONSTRUCTION traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GARRETT COOLEY NELLIE WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is sny injury or other trau once. ELVA R. COOLEY / SPOUSE 14301 LEWISDALE RD., CLARKSBURG, MD 20871 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMET. 2/24/04 FREDERICK, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) 20838 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (dr as a consequence of): /Medical Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Cancer ladder Due to (or as a consequence of): Box 68760, attending physicien ician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetel death Por in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o Physi 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Division of Vital 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D44164 -Z. HEGAZIIND 2-22-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A Z HEGAZ 46 B THOMAS MONS Thomas Monson Dr Frederick MD 21702 AZHEGAZI 45 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 2004 Registrar

		1 - For State Registrar  1. Decedent's Name (First, Middle, I		partment of Health and ertificate of Death		ne No. 2004 073
Physicia /Medic Examin	ai	Flora Chambe 4a. Facility Name (If not institution, g	rs	4b. City, Town, or Location of De	rebruary ath	Day 18 2004 2105  Ac County of Death Anne Arundel
uneral irector		1000 Madison 5. Social Security Number 6 578-20-1786 Usual Residence of Decedent	Street         Apt         A6           Sex         7. Age (In yrs. last birthda           1□M         2☑F         85   Yrs.	ay) If Under 1 Year If Under 24 H	rs. 8. Date of Birth n. (Month, Day, Yea	9. Birtholace (State or Fo.
r 28a-f show	Director	10a. State 10b. County  Maryland Anne  10e. Street and Number	Arundel Annapol		10g. (	10d. Inside City Li 1 ☑ Yes 2 ☐ Citizen of What Country?
"natural", or Itams 23a or 28a-1 show idical Examinet must be notified at	by Funeral	1000 Madison  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Street Apt. A6  12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes \$73.No If Yes, Give Year or Dates:	21403 3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 □ Yes 2 ☒ No Specify:	(Specify Yes or No- arto Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Black
r than	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of w DO NOT use retired)  Lography Techni	rorking	Kind of Business/Industry  ME Warren
g & S	To Be C	17. Father's Name (First, Middle, La  Basil W. Pe  19a. Informant's Name/Relationship	terson	18. Mother's N	ame (First, Middle, Maide nhine Will	en Sumame)
Item 2 othar		Sophronia M.  20a. Method of Disposition  MSBurial 2 Cremation 3  4 Donation 5 Other (Spec	Miller (Sister)  20b. Place of Discemetery, c  □Removal from State	6201 Sabine Dr position (Name of rematory or other place)	ive Favett Date 20c.	2830: Leville, N.C. Location - City or Town, State DWnsville, Mary
Important: If any injury or one		21. Signature of Funeral Service Lic		22. Name and Address of Facility		
nysician and me burial-transit	Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line.	lerotic He	Art Di.	Interval Batwae Onset and Dea
ysicia he bui	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B∐Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
		Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death
ate has page 2	Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings avair prior to completion of cause death?  1  Yes 2 No
fter this neral di	9	examiner?  1  Yes 2 No  27. Manner of Death  1  Whatural 5 Pending 2 Accident investigati		ent 3 DOA Other: 4 Nursing of 28c. Injury at	Home 5 Residence 28d. Describe how inju	
	cal Certification;	3 ☐ Suicide 4 ☐ Homicide  29a. Certifier (Check only)  2 ★ Medical Exe	building, etc. (Specify)  hysician: To the best of my knowledge, de.	ath occurred at the time, date and place	City or Town, Star	s) and manner as stated
To the Fu	Medical	29b. Signature and title of certifier	iminer: On the basis of examination and/or and manner stated.	29c. License number		ate signed (Month, Day, Year)
		30. Name and address of person who	comple ed case of death (Item 23a) (Type	a, Print)		1.00

			1 - For State Registrar	State of Maryland	/ Depa		lealth and M	lental Hygie	_	
			Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Yes	3. Time of Death
	Physici /Medio		PUTH DA	WENPORT				- 1	1 200	1 4 14
	Examir		4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, o	or Location of Death		4c. County of D	eath
			1373 Long Corne			Mount			Howard	
	Funeral		5. Social Security Number 6. S	I M 253 E	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	ear) 9.1	Birthplace (State or Foreign Country)
1.	Director		263-05-1059 Usual Residence of Decedent	92	TIS.			April 14	,1911 I1	<u>linois</u>
	land		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Mary	ō	Maryland Howa	~d M	011n+	Airy				1 ☐ Yes 2X No
	28e	rec	10e. Street and Number	ru rr	ount	· 10f. Zip Code		10g	. Citizen of What	Country?
	3a o	0	1373 Long Corner	Road		217	71		United S	States
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.		Hispanic Origin? (Spe an, Mexican, Puerto		14. Race - A	merican Indian,
စ္	or Ita	Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	}	ires, specify Cub 1 □ Yes 2⊠ No		mican, etc.)	Specify: V	
21215-0036	72 hours after death with the Maryland 'natural', or Itame 23a or 28e-1 show dical Examinar must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		103 223110	opecny.		Зреспу.	VIII CC
5-(	72 h	ete	15. Decedent's E (Specify only highest gr		(Give	tent's Usual Occup kind of work done	during most of worki	ng 16	b. Kind of Busine	ss/Industry
121	within ene. then "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	*		. 1 17	0. 1
	Hygie Hygie other t	S	8 17. Father's Name (First, Middle, Last	)	Owne	er/Operat	7	(First, Middle, Ma.	lotel Nev	vs Stand
ano	ad be	Be c	Louis Carlson					e Eva Wal		
Maryland	should ind Men in marke umatic	2	19a. Informant's Name/Relationship	Type Print)	19b Mailir	ng Address (Street	and Number or Rura			a Zin Code)
Ma	and 2 sho saith and n 27 is mu		Joan E. Davenpor							land 21771
ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyghene. If item 27 is marked other than "natural", or items 23s or 28e-1 show or other traumatic event, It a Madical Examiner main he notified at		20a. Method of Disposition	20b. Place		sition (Name of natory or other pla		ate 20	c. Location - City	
Ē	Page ento nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Burial 2 ☐ Cremation 3 ☐	THemoval from State		Memorial	I CDL u	ary 25 2004 W	inter Ga	rden, Florida
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other than any injury or other traumatic event, IL a Managange.		21. Signature of Funeral Service Lice				ess of Facility St.			
m	Depa Impo any ii		122	12	8	E. Ridge	ville Blvd	i. Mt. A	iry, Mar	yland 21771
E			23a. Part 1. Enter the disease, or com- shock, or heart fail me. List only	plications that caused the death. I	Do not ent	er the mode of dyir	ng, such as cardiac c	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Atherosclera	tie	Cardiou	ascular	Disease		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen-						
	LXammer	_	Sequentially list conditions,	b. Due to for as a consequent						
	bed isc	n le	cause. Enter Underlying Cause (Disease or injury	Due to for as a consequent	ce ori:					12
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	ce of):					
760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	calE		4						
68	ificate g phy as the			0.						
Вох	anding use	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		De			23d. Date of	delivery
	death e atte	lcia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fetal de		Ectopic pregnancy Other (specify) _	у		Month	Day Year
P.O.	The law requires that the death certificat ste has been signed by the attending phy sage 2 should be detached for use as th	Physician/Med	9 Unknown	9□ Unknown						
	signed I	by	Part II. Other significant conditions							to the cause of death?
Records,	w require been si should t	Completed by	170 malignant co	olonic polyps, h	70 t	reastcai	ncer	1 Tes	2 1 No 3 □	Probably 4 Unknown
ec	law las b	pje						24a. Was an autopsy	prior 1	autopsy findings available to completion of cause of
E B	The cate h	S						performed 1 ☐ Yes 2 🗓		
Vital	cien: ertific sctor,	Be	25. Was case referred to medical examiper?				26. Place of Death	(Check only one)		
of	Physicien: this certific ral director,	2	1 √res 2 No		Outpatier		4   Nursing Hor	ne 5 Nesidenc		pecify)
ů.	After Unera	lon;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	b. Time of Injury	Wor	rk?	28d. Describe how	injury occurred	
isic	uttendii death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	De 28e Place of Injury - At home	form etc		Yes 2 □No	28f Location (Street	at and Number or	Rural Route Number,
Division	or A after Direction by	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	, rairii, sir	eet, ractory, onice	,	City or Town, S	State)	Aurai Aoute Number,
_	spite	aC	29a. Certifier 1 ☐ <b>£ertifying</b> Pl	hysician: To the best of my knowled	dge, death	occurred at the til	me, date and place,	and due to the caus	se(s) and manner	as stated.
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Example)	miner: On the basis of examination and manner stated.	and/or in	vestigation, in my o	ppinion, death occurr	ed at the time, date	and place, and d	ue to the cause(s)
	To the To the Comp	X	29b. Signature and title of certifier	Dep	why	29c. Licens	se number	29d.	Date signed (Mo	onth, Day, Year)
			Testma &	Ly ws	ME	03	1473	Fe	b 11/0	4
	10		30. Name and address of person who	completed cause of death (Item 23	a) (Type,	Print)				
	Ψ		PATRYCE A. TOYE		nloch	c Cone l	Nay Ell	icoll Cit	y MD.	21042
G.	Sta		31. Date filed (Month, Day Year)	3 2004 Signature	A	Societ 1	7		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 14 07319

		•	1 - State Registrar			,	Ce	rtificate of l	Death	,	Reg. No.		01013
	Discrete!		1. Decedent's Name	(First, Middle, Las	it)					2. Date of De Month	ath	Year	3. Time of Death
	Physici /Medic		Judy	Eliza	beth	Dewit	:t			Februa	ry 23 2	2004	9:45 A M
	Examin		4a. Facility Name (If			oer)		4b. City, Town, or		ath		y of Death	
			5330 Kitz			Ago (In ure	last birthday)	Kitzmil:	Ler If Under 24 Hr	S. Q. Date of Ris	Garr		place (State or Foreign
	Funeral Director		5. Social Security Nu 381–44–81	28 1	M 20XXX	59	Yrs.	Months Days	Hours Mir	n. (Month, Da	1945 1945	1 _	place (State or Foreign ntry) NESSEE
	and and		Usual Residence of	10b. County		10c. Cit	ty, Town or Lo	ocation			·	1	10d. Inside City Limits
	Marylan f show led at	ō	MD.	Garrett			Kitzm	iller					1 ∐ Yes 🏋 🗓 No
	r 28a	Director	10e. Street and Num					10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h with		5330 Kit	zmiller	Road			2153	38		United	l Stat	es
980	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Itams 23a or 28a-f show evant, the Medical Evantian must be notified at	by Funeral	11. Marital Status  1 Never Marrie 3 Widowed		12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es? ⊠ <b>N</b> o		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)		ce - Americack, White, ify: Whi	etc.
9	72 ho	ted		15. Decedent's Ed			16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of E	3usiness/In	dustry
21215-0036	within ane.	Completed	Elementary/Secon	, , , ,	College (1-4	lor 5+)		kind of work done of DO NOT use retired	)	······g	house	work	
d 2	filed y Hygie other i		17. Father's Name (i	First, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maiden Suma	me)	
Maryland	2 should be filed withi and Mental Hygiene. is marked other than aumatic evant, I.e. M	To Be	Robert	Eli Be	lcher				Anna	Lee B	urke		
ary	₹ 5 E E	-	19a. Informant's Na		* .		1	ng Address (Street			•		
Σ	and 2 salth n 27 i		Franklin	Dewitt/	husband			Kitzmille				-	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 218	osition ∰remation 3 □	Removal from St	210	cemetery, cre	osition (Name of matory or other place		2/23/	20c. Location		
Ë	. Pag tment tant: jury d		* 4 □ Donation	5 ☐ Other (Specify	)	Cun		nd Cremato	- 20	004	Cumber	Tand	Maryland
Bai	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once.		21. Signature of Fur	neral Service Licen	0 (80		1	2. Name and Addres		Boal Fu			04550
			23a. Part1. Enter th shock, or hear Immediate Cause (F	t failure. List only	olications that cau	used the deat	th. Do not en	11 Church ter the mode of dyin	g, such as cardi			yland	Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		a. Due to (or	r as a conseq	UM )	Car	a	1		_	8 mayor
	Examiner			. 1			J						
	n =	ner	Sequentially list con if any, leading to impediate. Enter Under Cause (Disease or that initiated events	ditions, mediate fying	Due to (or	ras a conseq	quence of):						
	acuter ind trans	Examiner	cause (Disease or I that initiated events resulting in death) L	njury	c								
60,	ortificate be executed ing physician and e as the burial-transit		rodating in docum		Due to (or	r as a conseq	(uerice oi).						
68760,	physics the	Medical			. d								
. Box	ath ce	Physician/Me	JF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ▼ 9 □ Unknown	gonths?		h 2 ☐ Feta nt at time of d	al death 3[	Ectopic pregnancy Other (specify)				ate of delive onth	ery Day Year
, P.O	res that the de igned by the a be detached to	y Ph	Part II. Other signifi	cant conditions c	ontributing to dea	th but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use cor	tribute to th	he cause of death?
rds	quires in sign uld be	ed by								10	Yes 2□No	3 🗆 Prob	pably 4 Unknown
of Vital Records,	aw require is been si 2 should b	Completed								24a. Was		Were auto	psy findings available impletion of cause of
Ä	The lav ate has page 2	ĕ								perfo	ormed? 2 No	death? 1 ☐ Yes	2 No
ita	i <b>ician:</b> Th certificate rector, pag	Be	25. Was case referre	ed to medical						eath (Check only o	one)		-
₹	Physician: r this certific ral director,	2	1 ☐ Yes 2 🗖 1	No	Hospital: 1 ☐ Ing		ER/Outpatie		4   Nursing	Home 5 X Resi			y)
ono	ding P th. After t	tlon:	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of (Month,	Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occu	rred	
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide	6 Could not be determined	ZOB. PIACE O	f Injury - At h g, etc. <i>(Speci</i> l	ome, farm, st	reet, factory, office		28f. Location ( City or To		ber or Rura	al Route Number,
	To the Hospitel or Att within 24 hours after d To the Funarel Direct completely filled in by	Medical C	29a. Certifier (Check only one)			is of examina		h occurred at the tin vestigation, in my o					
	withir To th comp	Me	29b. Signature and	title of certifier	Λ.	1	7	29c. License			29d. Date signe	ed (Month,	Day, Year)
				47	Ju			Doo	60478		2/23	104	اسر
			30. Name and addre	ess of person who	completed cause	of death (Iter							
			Dr. Afac	Ahmad			625	Kent Ave.	, Cumbe	rland Mai	ryland :	21502	

Registrar

			1 - For State Registrar	State of Maryl	and / Depa		lealth and		_		
	hysici Medic		Decedent's Name (First, Middle, Las	Mary Jane	e DiFior	:e	-	2. Date of Death Month February	Day 25, 200	3. Time of Death 4 1:00 P M	
	xamin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o		h	4c. County of De Anne Ar	undel	
Dire	neral ector		5. Social Security Number 6. Security Number 217–32–4752 Usual Residence of Decedent	9X ☐ M 2 X F 7. Age (In ) 66	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, ) 09-12-19	9. E 937 Wa	Sirthplece (State or Foreig Country) shington, DC	
Maryland	ified at	ctor	10a. State 10b. County  Maryland Anne Ar		City, Town or Lo	nurchton				10d. Inside City Limits 1 ☐ Yes 2 💆 No	
with the	pana	Dire	10e. Street and Number			10f. Zip Code	20733	100	J. Citizen of What	Country?	
1215-0036  within 72 hours after death with the Maryland sheet and any second s	the Medical Evantrer must be notified at	by Funeral Director	1213 Ellicott Ave  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 _Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA  14. Race - Ar Black, Wi		
21215-0036 3d within 72 hours aff giene.	Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of world)	rking	6b. Kind of Busines		
ind 2 be filed tal Hygi	event,	To Be Con	17. Father's Name (First, Middle, Last)  Ralph F. Sc.	2 years hreiber	Senio	or Center	18. Mother's Nan	ne (First, Middle, Ma Nancy J. I	uiden Sumame)	nt of Aging	
	trau		19a. Informant's Name/Relationship (7 Christopher DiFio	,				Churchton			
O Se to	- ö		20a. Method of Disposition 1 Burial 2 Cremation 3  4 Donation 5 Other (Specify	I BITTO VALITION STATE	_	sition (Name of matory or other place rematory	3–3-		c. Location - City o		
Baltim permit. Pag Department	any injury once.		21. Signatury of Funeral Service Licens		22	2. Name and Addre	ss of Facility G	eorge P. K	Kalas Fun	eral Home	
Exam	dical	cal Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	CANCE):	of the mode of dyn	y, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death	
. BOX 6. death certific	or use as 1	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
The law requires that the tee has been signed by the	bed	þ	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	nderlying cause givi	en in Part I.	23e. Did tobac		to the cause of death?  Probably 4 Unknown	
	r, page 2 sho	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No				
On Of Jing Phy After this	funeral di	tlon: To Be	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Work	er: 4 □ Nursing H	ath (Check only one)  Home 5 Residence 6 Other (Specify)  28d. Pescribe how injury occurred		
	d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streetly)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,	
To the Hospital or within 24 hours after To the Funeral Dir	pletely fille	edical	29a. Certifier (Check only one) 1. Certifying Phy 2 Medicel Exemptone)	sician: To the best of my kiner: On the basis of examinand manner stated.	knowledge, death ination and/or inv	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner a and place, and du	is stated. e to the cause(s)	
To ti withi	Сош	Ž	29b. Signature and title of certifier	ires, MD		29c. License D 525			Date signed (Mon		
			30. Name and address of person who con Jeanine Wein	er, 900 Best	tem 23a) (Type, Gate Ro	Print) ad #30	O, Annay	polis, N	10 21	25,2004 401	
Re	Stat egistra	te ar	31. Date filed (Month Day Year) FEB 2 7 2	32. Registrar's Sig	inature	1					

ORIGINAL

			1 - For State of Registrar	f Maryland		rtment of H tificate of L			Re	ene 3. No. 20	104	07321
j	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, Last)  Carl George Degen, Jr.  4a. Facility Name (If not institution, give street and nun 1024 Shore Acres Road	nber)		4b. City, Town, or	Location of	F	Date of Death Month Peb.	4c. County	Year 2004 of Death	3. Time of Death  11:55 p M
	Funeral Director		5. Social Security Number  578-26-5404  Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Dey, ) lar. 13,			ace (State or Foreign try) OH
	hours after death with the Maryland lurel', or Hems 23a or 28a-f show at Examinations be modified at	ector	10a. State 10b. County 10b. Anne Arundel 10e. Street and Number	10c. City,	Town or Lo	Arnold	i .			0111		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	heath with	by Funeral Director	1024 Shore Acres Road	dent Ever in U.S.	13. V		21012	1? (Specify			JSA e - America	
5-0036	n 72 hours after death with the Marylan *naturel", or flems 23a or 28a-1 show skifcal Examilher mast be motified at		1 Never Married 2 Married 1 1 Yes, Giv 3 Widowed 4 Divorced Year or Da	rces? 2 □ No e WWI ites:	I 1	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 No	Specify:	Puèrto Ric		Specify	k, White, e Whi	ite
-61212	within 72 ane. than "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1  4	45-)	(Give I life. D	ent's Usuat Occupa kind of work done d OO NOT use retired, Producer	luring most o )		τ	ib. Kind of Bu J.S. Fe Overnii	ederal	
Maryland	should be filed ind Mental Hygis marked other umatic event, III	To Be (	17. Father's Name (First, Middle, Last)  Carl G. Degen, Sr.  19a. Informant's Name/Relationship (Type, Print)		10h Mailin	Address (Street	Laur	a Lee	irst, Middle, Ma e Linger	nfelte	r	2-4)
	1 and 2 Health a tem 27 is		Paula Degen/Wife  20a. Method of Disposition	20b. Plac	1024	g Address (Street a Shore Ac sition (Name of latory or other place	res Ro	oad, Z	Arnold,	•	1012	
altimore,	permit. Pages Department of Important: If i any injury or o		1 ☐ Burial 2 【XCremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenge		etro C	rematory Name and Addres	s of Facility	eb. 2 _2004		Baltin		
מ			23a. P. 1. Eter the disease, or conficiations that ca shock, heer failure. List only one cause on ea In ediat cause (Final	aused the death,	Do not ente	r the mode of dying	, such as ca	rdiac or re	Sever Sever Sever Sepiratory arres	t,		neral Home 21146 Approximate Interval Between Onset and Death
9/00,	certificate be executed  X Medical function and ding physician and see as the burial-transit	Ilcal Examiner	dismark representation resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequent	nce of):		<i>)</i>					3mes
O. Box 6	death certific e attending p id for use as	Physiclan/Med	in the past 12 months?	come of pregnanc rth 2 Fetal de ant at time of deat wn	ath 3 🗆	Ectopic pregnancy Other (specify)				23d. Date Mor	e of deliven	y Day Year
cords, r	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to de	ath but not resulti	ng in the un	derlying cause give	n in Part I.			~/		e cause of death?
Hec	The law ate has b page 2 s	Completed						_	24a. Was an autopsy performe	<u>r</u> d? ∣ d	eath?	sy findings available pletion of cause of
ion of Vital	S S	atlon: To Be		-	VOutpatient Bb. Time of Injury	3 DOA Othe	r: 4 🗆 Nursi	ng Home 28d.	theck only one)  5 Fesidence  Describe how			-
DIVISION	ital or Atterns after destail Director	Certification:	3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home g, etc. (Specify)					Location (Stree City or Town, S	State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only only  20 Medical Exeminer: On the ba	sis of examination	edge, death n and/or inv	occurred at the time estigation, in my op	e, date and pinion, death	place, and occurred a	at the time, date	se(s) and man and place, a Date signed	nd due to t	the cause(s)
	¥ ¥ 8		30. Name and address of person who completed paus	of death (Item 23	3à) (Type. F	1)26	74	13	1	7/2	3/0	cu tou
	Sta		31. Date filed (Month, Day, Year) 32.	S /c	4	105	1/6	De	nnap	Hu	no	74111400
	Registr	ar	FEB 2 7 2004	Mary D	5.0	2002			•			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Eva Jesse Eckhart February 20, 2004 12:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Jefferson 3867 D Jefferson Pike If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 110 Months 1 □ M 202 F 209-12-3238 Director May 26, 1893 Pennsylvania Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mentel Hygiene. Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Directo Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21755 United States 3867 D Jefferson Pike Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐ Yes 2 ☑ No f Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed by 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Bullock Isaac McKinley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bryan Groff / Great Nephew 4112 Sturbridge Ct.; Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 21, 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of uneral Service Licen 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) rduvascula (Dieza Examiner Due to (or es a consequence of): Physician/Medical Examiner ettending physician end for use es the bunel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) funeral director, page 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yue 3L No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) After this Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Naturel 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 preary 21,2004 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 7th St. Frederick, MDZ1701 VLI Trou

**DHMH 16 Rev 6/95** 

State

Registrar

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2004

32. Registrar's Signature

			1 _ For	State of Ma	aryland	d / Dep	artmen	t of H	ealth a	and M	ental Hy	giene	2004	ח־ו	323
	à.		Registrar  1. Decedent's Name (First, Middle, Last)			Ce	rtificate	e of L	Jeath		2. Date of De		.2004		of Death
100	Physici	an		Enfinge							Month Februa:	Da	y Year 1,2004	6:31	Λ M
	/Medic Examin	100	Billy W 4a. Facility Name (If not institution, give		Ľ		4b. City,	Town, or	Location of		rebi ua.		County of Deat		A
	_ Add.	Bria.	Frederick Memoria	l Hosptal					deric				Frede		
	Funeral	1111	5. Social Security Number 6. Security Number 1.	KM 2DE		st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. Birt Co	nplace (State untry)	or Foreign
T.	Director		261-42-7339 Usual Residence of Decedent		70						Sept.	/ <b>,</b> 1	933 F.	orida	
	yland how		10a. State 10b. County		10c. City,	, Town or Lo	ocation							10d. Inside	
	8e-fs	Director	Maryland Frederic	ck	Midd	1etow									es 2⊠No
	with ti		10e. Street and Number				10f. Zip		7.00			_	tizen of What Co		
	ms 23	Funeral	318 South Church S	12. Was Decedent I	Ever in U.S	6. 13.	Was Deced		769 spanic Ori	gin? (Spe	crfy Yes or No Rican, etc.)		ted Stat	ncan Indian,	
ထွ	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1    Yes 2   N  Yes, Give	io		1 Yes, spec				Rican, etc.)		Black, White		
003	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Madical Exercities maal be codified at	d by	3 🗷 Widowed 4 🗆 Divorced	Year or Dates:	1950-	52	dent's Usua					165 8	ind of Business/	ite	
5	in 72 n *nal	plete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of wor DO NOT us	k done d	during most	t of workir	ng	100. 1	and of bosiness	ildustry	
212	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		Car Sa	alesi					tail Aut	o Sal	es
Maryland 21215-0036	be filed tal Hygi d other event.	Be	17. Father's Name (First, Middle, Last)								(First, Middle	_			
Z	should ind Men ind marke umatic	2	Coley Chaffin Enf:  19a. Informant's Name/Relationship (T)			19h Maili	na Address	(Street a			Boute Numb		en or Town, State, 2	in Code)	
<u>S</u>	and 2 s lealth an m 27 is i		Pamela Taylor/ Day									-	n, Mary]		1769
Je,	es 1 ar of Hea f item r othe		20a. Method of Disposition		20b. Pto	ace of Disponentery, cre	sition (Nan	ne of		D	ate		ocation - City or		
Ĕ	Pages rent of ont: If it ury or o		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Sale	em Uni	ted M	etho	dist	2/24, Ceme	tery	Ced	ar Grove	. Mar	yland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other treumatic event. The Maclical Exaction man Le rolling at once.		21. Signature 1 Funeral Service Licens	Uku	N	₹ 2	2. Name an 1 in L 6401 I	d Addres Mo Ridge	is of Facilit Leswo e Roa	rth l	P. A., amascus	Funda, Ma	eral Homaryland	e 20872	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications mai caused ne cause on each lir	the death.	. Do not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
18	Physician		Immediate Cause (Final disease or condition resulting in death)	CARD	DAG	A	125	-						Onset and	intes
П	/Medical Examiner		resulting in dealth)	Due to (or as	a consequ	ence of):	}							VO	2-4
¥	*	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):	erg	1	1200					7-20	0 5
	cuted nd ransit	Examiner	tust initiated events	c											
760,	e be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of);									
387(	icate b physic	dical		d											
X	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75						23d. Date of del	very	
P.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunat-transit	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pr □ Other (sp						Month	Day	Year
٥.	s that ned by e deta	y Ph	Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the u	inderlying c	ause give	en in Part I.		23e. Did 1	obacco	use contribute to	the cause of	f death?
ıds	equire en sig ould b	ed b									1 🗆	Yes 2	□No 3□Pr	obably 4	Unknown
Vital Records,	law re las be	Completed									24a. Was	psy		topsy finding completion of	
四四	: The										1 Tes	2 N No	death? 1 ☐ Yes	2□ No	
<u> </u>	Physician: The lav this certificate has al director, page 2	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2⊠No	Hospital: 1 ☐ Inpatie		R/Outpatie	at 20 00	Othe	OF:		(Check only		6 ☐Other (Spec	·i6.1	
o	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju-	ry	28b. Time o		8c. Injury Work	at		8d. Describe	_		агу)	
ion	ending sath. or: Aft he fun	atlo	1 Natural 5 Pending 2 Accident investigation	(MONIII, Da)	, , , ,	Injury	М		Yes 2 🗆	No					
Division of	after de l Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc			reet, factory	, office		2	tsf. Location ( City or To		nd Number or Ru a)	ral Route Nu	ımber,
	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one)  (Check only one)	sician: To the best of ner: On the basis of and manner sta	examinati										e(s)
	ro the	Me	29b. Signature and title of certifier	and manner ste			290	. License	number			29d. Da	te signed (Monti	n, Day, Year)	
)	0		In Hotoon	- M	1			D	27	194	9	E	eb 2	4 20	004
1	2+1		30. Name and address of person who co	ompleted care of d	eath (Item	23а) (Туре	Print)	1111	10.35	1.	1 6	_	1	1	
0	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	MI	111	IU Me	dica.	L Campu	ıs Ro	oad, Hag	ersto	wn MD.
	Regist	rar	FEB 2 6 2	004		D.	Spark.	P							

DHMH 17 Rev 1/2001

5	Exa	iec im
b		
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed	within 24 hours after beaut. To the Funeral Director: After this certificate has been signed by the attending physician and

	1		Maryland / Depa	artment of Health and M rtificate of Death			07324
Physicia	_	Decedent's Name (First, Middle, Last)		H	2. Date of Death	D22.2004	3. Time of Death
/Medica Examine	al -	Robert John Flahe ta. Facility Name (If not institution, give street and num Memorial	erty, Jr. Hospital	4b. City, Town, or Location of Death Easton	CETAGET	4c. County of Death	"
Funeral Director		5. Social Security Number  218-16-6704  Usual Residence of Decedent	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y October1	9. Birth Con 4,1924 Man	place (State or Foreigr intry) 'yland
a-f show	ctor	10a. State 10b. County  Maryland Talbot	10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28	Dire	10e. Street and Number		10f. Zip Code	100	. Citizen of What Co	intry?
72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinat must be mutified at	/ Funeral Director	1 Never Married 2 Marned 1 Types	2 □ No	21601 Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 21 No Specify:	acity Yes or No- Rican, etc.)	USA  14. Race - Amer Black, White	
od within 72 hours aft giene. er than "natural", or i. The Medical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	ident's Usual Occupation Is kind of work done during most of worki DO NOT use retired)	ng 16	6b. Kind of Business/I	White:
2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", surmatic event, The Medical Exa	Be	College (1  17. Father's Name (First, Middle, Last)		trical Engineer 18. Mother's Name	(First, Middle, Ma		es Navy
a Men narke	٥	Robert John Flaherty,  19a. Informant's Name/Relationship (Type, Print)		Elizabet		lick City or Town State Z	in Code)
1 and 1 and 1 ealth 1 ear tr		Jean Flaherty / wife  20a. Method of Disposition  1 □ Burial 2 Ø Cremation 3 □ Removal from	20b. Place of Dispo	243 Pin Oak Way, E osition (Name of matery or other place)	laston, Ma Date 20	ryland 216 oc. Location - City or	oun, State
permit. Pages 1 at Department of Hea Important: If item any injury or othe Once.		21. Signature of Funeral Service Licensee  23a. Part Enter the disease, or complications that c	e	2. Name and Address of Facility Bennie Smith Fune 426 Dover Street,	ral Home Easton,	Maryland 2	
bur icia	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infrated events		Long Car	cinon	200	Interval Between Onset and Death
s death cert he attendin ed for use	by Physician/Medi	23b. Was decedent pregnant 1 Live b	nant at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
v requires that the been signed by the should be detach	ed by Pt	Part II. Other significant conditions contributing to d	eath but not resulting in the t	underlying cause given in Part I.		cco use contribute to	the cause of death?
Physicien: The law requires to this certificate has been signe rail director, page 2 should be a	Completed	disease				1 ∐ Yes	topsy findings available ompletion of cause of
ding Physicien: Th h. After this certificate funeral director, pag	on: To Be		inpatient 2 ER/Outpatie of Injury th, Day Year)  28b. Time of Injury	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work?	n (Check only one) me 5 ☐ Residen 28d. Describe how	ce 6 □Other (Spec	erfy)
i gite	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home, farm, si ing, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical C	(Check only 2 Medical Examiner: On the b		eth occurred at the time, date and place, nvestigation, in my opinion, death occur			
To the withhin To the comp	W	29b. Signature and title of certifier	ald	29c. License number	296	d. Date signed (Month $2/22/26$ )	n, Day, Year)
Sta Registr		30. Name and address of person who completed cause Dr. Dennis Deshields 31. Date filed (Month, Day Year) 2 4 2004.		shington Street. Ea	iston,Mar	yland 216(	)1

			For State Registrar				nd / Depa	artme	nt of I	Health and Death	d Menta	al Hygie	_		073	
	Physici		1. Decedent's Name (First Lotte	it, Middle, Last) He1en	а	Fir	th				Mc Mc	te of Death onth	Day 25 =	Year 2004	3. Time of 0	Death A M
	/Medic Examin		4a. Facility Name (If not in	nstitution, give s	treet and num	iber)		4b. City	y, Town,	or Location of De			4c. County			
		<b>%</b>	Doctor's Co	mmunity	Hospi	tal			ham				Prince			
	Funeral Director		5. Social Security Number 056-26-6065	1 🗆	M 21XF		last birthday) 36 Yrs.		er 1 Year s Days		lin. (M	te of Birth o <i>nth, Day, Ye</i> y 19,		9. Birthp Coun Germ	lece (State or itry) any	Foreign
	and *		Usual Residence of Dece 10a, State 10b.	County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City	y Limits
	death with the Maryland ms 23a or 28e-f show rmst be notified at	Director	Maryland Pr	ince Ge	orges	Mi	tchellv	7ille	2						t <b>y</b> ∑Yes	2 🗆 No
	or 26	Dire	10e. Street and Number						Zip Code			10g.	Citizen of \	What Coun	itry?	
	s 23e			sford R		C2-55			0721	Historia Osisia?	(Casaib. V	N	U.S	A. e · Americ	on Indian	
2 29	P 25 3	by Funerai	11. Marital Status 1 ☐ Never Mamed 3 ☐ Widowed 4 ☐ [	2X Married	12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 ∑ No e		If Yes, sp		Hispanic Origin? ean, Mexican, Pu Specify:	ierto Rican,	etc.)	Blac	ck, White,	etc.	
eth, Lotte Helena Baltimore Marvland 21215-0036	72 hc	Completed	(Specify on	Decedent's Educity highest grade	completed)		16a. Dece (Give life.	dent's Us kind of w	sual Occu vork done use retire	pation during most of a	working	16	b. Kind of Bi	usiness/Ind	dustry	
212	with giene.	omo	Elementary/Secondary	(0-12)	College (1-	4or 5+)				stor		I	nsura	nce		
7 5	at Hyg other	BeC	17. Father's Name (First,	Middle, Last)			·			18. Mother's N	Name (First	, Middle, Mai	den Suman	10)		
V = 2	Mente Mente arked artic s	To	Joseph		]	Eisner				Maria			Parc			
Mar	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natu any injury or other traumatic svent, I.a. Medical		19a. Informant's Name/Fi	1 1 77		ghter		_		tand Number or t SE, Wa				State, Zip 2002	_	
7 0	f Head		20a. Method of Disposition				Place of Dispo	sition /N	ame of		Date		c. Location -	City or To	wn, State	
ري <u>ت</u>	Page Dent cant: If		1 □ Burial 2 🗖 Cre `4 □ Donation 5 □	mation 3 ⊟R Other <i>(Specify)</i>	emoval from S	otate	ntt Cre				26/200	04 W	aldori	E. Ma	ryland	
rieth, Baltin	epartr epartr epartr ny inju		21. Signature of Funeral	Service Lens	6					ess of Facility		t E. E	vans l	uner	al Home	e
7	20529		1	1/2						apolis 1				/land		
•	Physician		23a. Part 1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)		cations that called cause on ea	Spi	ratio	ter the mo	ode of dy	veu		ratory arrest			Approximate Interval Betw Onset and D	vee∩
	/Medical Examiner		Samuentially list condition		Due to (	or as a conse	quence of):									
	uted 1 ansit	Examiner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury that initiated events	ate	Due to (	or as a conse	quence of):									
760	te be executed ysician and le burial-transit	cal Exa	resulting in death) Last		Due to (	or as a conse	quence of):									
œ e	rtifical	Medi	IF FEMALE:													1
Division of Vital Records DO Roy 68	Attending Physician: The law requires that the death certificate relation.  The law requires that the death certificate octor. After this certificate has been signed by the attending physic the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pred in the past 12 mont 1 Yes 2 No 9 Unknown	mant		inth 2 ☐ Fet ant at time of	al death 3	⊒Ectopic ⊒ Other (		<b>у</b>				te of delive Inth		ear
ā G	uires that I		Part II. Other significant	conditions con	ntributing to de	eath but not re	sulting in the u	inderlying	g cause g	ven in Part I.	2		co use cont		ne cause of de	
Ş	w requires to the second of th	iete	.5	trake	> _				-		2	4a. Wasan	24b.	Were auto	psy findings a npletion of ca	vailable
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ž.	ician ician sertifi	Be	25. Was case referred to examiner?		lospital: , 🛶					26. Place of I						
4	Phys this ral dir	. To	1 Yes 2 No		1 (28)		28b. Time o		DUA	4 (14013111		Residence			r)	
2	ding th.: After	tion		Pending investigation	(Mont	of Injury h, Day Year)	Injury	м	28c. inju	ork? ]Yes 2 □No	200.0	000/100 1101	injury occur			
Divie	all or Atters after dea	Certification:		Could not be determined	28e. Place buildin	of Injury - At h	nome, farm, st	reet, facto	ory, office		28f. Lc	cation (Streety or Town, S	et and Numb State)	er or Rura	I Route Numb	er,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only 2 one)	Certifying Phys Medical Examin	sician: To the ner: On the ba and mann	asis of examin	owledge, deat ation and/or in	th occurre	ed at the toon, in my	ime, date and pla opinion, death o	ace, and du ccurred at t	e to the caus he time, date	se(s) and ma and place,	anner as st and due to	ated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title	at the same of the	, ,	)			34.0	se number	~		Date signe			
			D K	Dak	her	our V	)		00	16 49.	×		2/2	5/0	4	
			30. Name and address of	erson who co	mpleted caus	e of death (Ite	m 23a) (Type,	Print)		CH 9		D Donger	/ 22	Bow	12 My	)
i			31. Date filed (Month, D	LHEEL,	1 30 0	Strar's Sign	No Tet	2/1/	166	E ROXE	1 20	1127 H	QB	90	716_	
	Regist	ate rar	on bate mos (month) o	B 2 6 2	02111		M	down	<i>2</i> 8							

		1	For State Registrar	State of Maryland /	Department of F		Mental Hygie	_ Z U U !	+ 07326
.4	T & -		Decedent's Name (First, Middle, Last	)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		DONALD E.	CALLAHAN				25 2004	0946 <sup>M</sup>
4	Examin		4a. Facility Name (If not institution, give	street and number)		r Location of Death		4c. County of Dea	
		9.	MEMORIAL HOSPITA			TON  If Under 24 Hrs.	2 Date of Birth	TALBO'	
	Funeral Director		5. Social Security Number 6. Se 11 12 13 15 15 15 15 15 15 15 15 15 15 15 15 15	x 7. Age (In yrs. last b	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	1947	thplace (State or Foreign ountry)  MO
	14		Usual Residence of Decedent				112015	1317	
	inylan ihow	_	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits 1 XYes 2 □ No
	Ba-1 s	Funeral Director	MD TALDU	EAS	10f. Zip Code		100	Citizen of What C	
	with the or 2		10e. Street and Number CORI	RINI DARKWA	V 2	1601	Tog.	USA	outrity?
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ami	
9	or Iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	If Yes, specify Cub	an, mexican, Pueni Specify:	o Hican, etc.)	Black, Whi	
2-003	within 72 hours after death with the Maryland ene. than "naturel", or liems 23e or 28e-f show tha Maylcal Extrainer must be rotified at	d by	3 Widowed 4 Divorced	Year or Dates:			140		
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2121	iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	ADMINISTRA'	TOR		EDUCATIO	N
פ	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or Items 23e or 28e-f show other than "naturel", or Items 23e or 28e-f show event, Ite Marylan Extendible for the follited at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Maid	den Sumame)	
<u>8</u>	should be filed within nd Mental Hygiene. I marked other than umatic event, Its M	10	DAN CALLAHAN			1	SPARKS		
Maryland	2 2 2 2	1	19a. Informant's Name/Relationship (7		b. Mailing Address (Street 29250 CORBIN				Zip Code)
	s 1 and of Health item 27 other tr	-	JANICE CALLAHAN/W.  20a. Method of Disposition	20b. Place	of Disposition (Name of	1		. Location - City or	Town, State
μoμ	Pages nent of I int: If it		1 Burial 2 Cremation 3 \( \) 4 Donation 5 Other (Specify	Removal from State	ery, crematory or other pla ENT PARK		-2004 MEI	RRILLVILI	E, IN
altimore,	그 든 만 중	1	21. Signature of Funeral Service Licent		22. Name and Addre				S. HARRIGONST
Ö	permi Depa Impo any ir		Closeph M. Os	nowski C.f.S.P.	FELLOWS,	HEFLEBE	INZNEV	NAM EA	STON MD 2160/
20.0			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Done cause on each line.	o not enter the mode of dy	ng, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	· MYOCARDII	L INFA	RCTION,	ACUTE		Houte
	/Medical Examiner		Tooland in doarny	Due to (or as a consequenc	E CARDIOXI				Citania
ų.		e	Sequentially list conditions, if any, leading to immediate	b. Dee to (or as a consequence		SCULITIC	NISEITS		CHRONIC
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	С.					
o,	ate be executed hysician and the burial-transit	Exe	resulting in death) Last	Due to (or as a consequence	e of):				
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical	•	d					
9 xo	leath certifics attending pl	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pregnancy				23d. Date of de	livery
$\mathbf{\alpha}$	atten for u	clan	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Month	Day Year
Ö.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown					
S, D	The law requires that the ate has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions of	entributing to death but not resulting	in the underlying cause gr	ven in Part I.			o the cause of death?
ord	v requir been si should I						1 ☐ Yes		robably 4. Unknown
ec	a law has b e 2 st	Completed					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
Vital Records,			OS IMan annu referred to modical			00 Bloom of Door	1  Yes 2 X		s 2 No
₹ 	Physician: The lav this certificate has ral director, page 2	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🛣 ER/6	Outpatient 3 DOA Ott	200	ith (Check only one) lome 5 🗆 Residence	e 6 ∏Other (Spe	acify)
of Of	g Phy er this	<b>-</b> ,	27. Manner of Death		. Time of 28c. Inju		28d. Describe how i		,
Sior	Attending ir death. ector: Atter by the fune	atlo	1 Natural 5 Pending 2 Accident investigation			Yes 2□No			
Division	I or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stree City or Town, S		lural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a, Certifier 1 Certifying Ph	ysician: To the best of my knowled	ge, death occurred at the ti	me, date and place	, and due to the caus	e(s) and manner a	s stated.
	e Hos 24 hr e Fun letely	edical		iner: On the basis of examination and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	DEPU	TV 29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)
,			Mirustean Fren	LEUIND MIE	J 114	1664	F	EB 26	4007
			30. Name and address // pe on who	her Mail	(Type, Print)	71/ MI	2162		
p	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	- JUJUENI	UIV IIV			
			FEB 27 200						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:44 PM February 23, 2004 Josephine Prencipe Goff /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Bowie Bowie Health Care Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2**X** F New York Yrs. Aug. 29, 1928 75 Director 579-32-8563 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a nr nearly any injury or other traumating. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Bowie Director Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 USA 2610 Kingsley Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2XNo 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No White Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosina Gallucci Michael Mario Prencipe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20715 Bowie, MD Cathy Downey/ Daughter 2610 Kingsley Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 3/2/2004 Arlington, VA \* 4 ☐ Donation 5 ☐ Other (Specify) Cemetery
22. Name and Address of Facility
Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee once. 16000 Annapolis Road Bowie, MD 2 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ara 190 resulting in death) /Medical Due to (or as a consequence of): **Examiner** orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 □Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performe 2 🗆 No 20 No 1 ☐ Yes 1 ☐ Yes Attending Physicien: rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospitel 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certific 2-24 30. Name and address of person who completed cause of death (Item 23a) (Type Print) (B-) [ CC, 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State **FEB 2 5** 2004 Registrar

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2:38 PM PETER GEORGE 28 FEBRUARY 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner. BALTIMONE

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. CITY HOPKINS HOSPETAL JOHNS Date of Birth (Month, Day, Year) Jul 13, 1957 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) . . . 5 Social Security Number **Funeral** "WV 1 X 2 F 217-66-3227 46 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits State 10h Count or 28e-f show Ällegany Cumberland 1 □XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 245 Goethe Street 21502 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married
3 Widowed 4 Divorced 1 Yes 2 No ò Baltimore, Maryland 21215-0036 Specify: white þ neturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) Be Elmo Clyde Hott Helen (Boyer) George Knapp 19a. Informant's Name/Relationship (Type, Print) Helen Knapp and Number or Rural Route Number, City or Town, State, Zip Code 19b. Mailing Address (Street and Number of Fig. 16125 McMullen Hwy. MD 21502 mother Cumberland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home 3/2/2004 MD Cumberland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name Scarpellio Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA DAYS Privsician /Medical Due to (or as a consequence of): **Examiner** MALNUTRITION MONTHS Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed PANCREATIC MONTHS Due to (or as a consequence of) attending physician P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. page 2 should be 3 Probably 4 XUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 K Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 🛣 No the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical with n 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified RES-000 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 600 NORTH WOLFE STREET, DALTIMONE, MD MAVES 31. Date filed (Month, Day, Year) State

frank ?

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February 2004 **Physician** 9:43 AM Marguerite Mullican Harsh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Kline Hospice House Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 15 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 21 F 220-26-5669 74 Yrs. 1929 Brunswick, MD July Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State A Health and Mental Hygiene. items 23 or 28a-f show item 27 is marked other than "neturel", or items 23a or 28a-f show other treumstic event, the Modest Experient must be notified at 1 XYes 2 No Brunswick Frederick MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21716 USA 1201 Maple Terrace Lane, Apt. 505 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Business Insurance Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Mary Elizabeth Darr Edwin J. Mullican, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 5th Avenue, Brunswick, MD 21716 of Health a Nancy E. Baker, Step-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Important: if any injury or once. Park Heights Cemetery 2/26/2004 Brunswick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tue 1 Tineral Service Eicensee/
Barbara A. Williams, Owner 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 2 □ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cher (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. i Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funerei I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 d U3c 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 1 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician**  $P_{\bullet}^{M}$ 8:27 February 25, 2004 Velma Hamilton /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1670 Homewood Landing Rd. Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Nov. 30, 1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2√2 F 75 Yrs. 171-24-0182 Pennsylvania Director Usuel Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f ahow f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28a-f ahow other traumatic event, the Medical Examples must be notified at 1 ☐ Yes 2 ☐ No Chenango Norwich Director New York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 13815 4918 Rt. 23E Chenango Lake Road death Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. perriit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Imp crtant: If tem 27 is marked other than "natural", or Nem
any injury or other traumatic event, the Medical 1 □ Yes 2 Tho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Dept. of Corrections 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Vesalonivich Anna Havrilko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 1670 Homewood Landing Rd. Annapolis, MD. 21401 June H. Paul 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Cutr. Feb. 28, 2004 Stevensville, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer & Service Licensee 22. Name and Address of Facility Adams Funeral & Memorial Care M00982 814 Bestgate Rd. Annapolis, Maryland 21401 YO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OSOPHAG eal Carrier Immediate Cause (Final disease or condition /2 YVY **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 □ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1XYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 🗌 Yes 2 No or Attending Physician: daughte's 25. Was case referred to medical 26. Place of Death (Check only one. Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Nther (Specify) vesidence 1 ☐ Yes 2 No 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 MNatural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To tha Funeral Director: A investigation 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/26/2004 secoun 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print).

S. SCONICU, WWO GOO BECTO CHE Rd. Aunapolis, Nd. 21401 900 Siscionicu, Mo

State Registrar 31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

		_	For State Registrar	State of Mar	yland / De C	ertificate of	Death	Re	g. No.	07331
	hysicia		1. Decedent's Name (First, Middle, Las Robert Edward		S			2. Date of Death Month	Day Year 24 2004	3. Time of Death 8:05PM
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medica Examine	100	4a. Fecility Name (If not institution, give		.5	4b. City, Town, o	r Location of Death	1	4c. County of Death	
			Doctor's Community			Lanhan			Prince Geo	rges
	neral ector		000 20 013)	7. Age	(In yrs. last birthd 91 Yrs	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 1,		place (State or Foreign intry) York
and	*	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
Maryl	notified at	to	Maryland Prince (	Georges	Mito	chellville				1 XYes 2 ☐ No
EdWard	23a or 28e ust be notil	Direc	10e. Street and Number 10450 Lottsford I	Road Apartm	ent 1202	10f. Zip Code 2 20721	L	10	g. Citizen of What Cou U.S.	
. <b>9</b> a		by Funeral Director	11. Marital Status  1  Never Married 2 Married  3 Note: Wildowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of H If Yes, specify Cubz 1 ☐ Yes 2√ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Amer Black, White Specify Whit	, etc. Ce
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an Id be ental	ked o	To Be	George William I	Harris			Anna		Schmidt	
S/S ary shound M	umat	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. M	lailing Address (Street	and Number or Rur	al Route Number,	City or Town, State, Z.	ip Code)
ARREIS, re, Maryl s 1 and 2 should if Health and Mary	or tra		Patricia Harris/ I	Daughter	122	15 Maycheck	Lane, Bo	owie, Mau	ryland 207	15
HAM more	int: If iten iry or oth		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		Sacred	amatawii	3/1/	2004 1	Rowie, Mary	and
<b>Bafti</b> permit. Departn	Imports any inju once.		21. Signature of Funeral Service Licen	see		22. Name and Addre			Evans Funer e, Maryland	
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Phys	sician		Immediate Cause (Final disease or condition	Lower	Gast	rointes	tinal f	(Rmn	orrhage	Onset and Death
1987-200	edical miner		resulting in death)	Due to (or as a	consequence of)	:			Q	0 -
LAG	A S	_	Sequentially list conditions,	bDue to (or as a	consequence of)					
petr	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury							
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68760, ificate be ex	ysicia ne bur	edical	(	d						
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Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death cert	ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deli Month	very Day Year
ds, P.O.	sben signed by	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in the	he underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, to Attending Physician: The law requires tighter death.	has 3e 2	Completed						24a. Was ar autops perform	y prior to death?	topsy findings available completion of cause of
tal	certificate rector, pag		25. Was case referred to medical				26. Place of Dea	th (Check only on		420110
f Vi ysicie	is cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 X npatier	nt 2 ER/Outp	atient 3 DOA Ott	ner		nce 6 Other (Spec	city)
ion of	To the Funerei Director: After this certific completely filled in by the funeral director.	ation: 1	27. Manner of Death  D⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Tin	ury Wo	ry at rk? ] Yes 2 □ No	28d. Describe ho	w injury occurred	
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	204		30. Name and address of person who	EL MO.	4000	ype, Print) NTTC(12/1	VILLE RO	AD 5017	F 2166	80W12 MD)
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		1	For State Registrer	State of Maryland			of Healt			iene g. No. 20 (	) L	07332
			Decedent's Name (First, Middle, Last)			<del> ·</del> · ·			2. Date of Deat		,	3. Time of Death
	Physicia		Marie A. Hal	e					February	7 25,200	rear 4	5:30 A.M.
	/Medic Examin	_	4a. Facility Name (If not institution, give st	treet and number)		4b. City, T	own, or Locat			4c. County of		
	Examin	G I	Annapolis Nursing 8		er	Anna	apolis			Anne	an	ındel
Z.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day)			ace (State or Foreign
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	2		Usual Residence of Decedent	100 Cib	y, Town or Lo	nation					10	d. Inside City Limits
	anylar ahow	_	10a. State 10b. County		Hyatts							1 TyYes 2 □ No
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	death with the Maryland me 23e or 28a-f ehow r must be notified at	Funeral	5805 42nd Avenue	2. Was Decedent Ever in U.	S 13	Was Decede	20781	<u> </u>	ecify Yes or No-	USA 14. Race	- America	ın Indian,
	item item	nu	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces? 1 □Yes 2 1 No	0. 10.	If Yes, speci	ify Cuban, Me	xican, Puerto	ecify Yes or No- Rican, etc.)		White, e	
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Maryland	C1 68	i i	19a. Informant's Name/Relationship (Type Steven M. Hale/ Son							r, City or Town, S		Codey
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altimore,	permit. Pages 1 are Department of Hea Importent: if item any injury or othe	1	*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		las Cr					Kalas F		
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Ö	Attending r death. sctor: Afte by the fune	atio	2 Accident 5 Pending investigation			М	1 🗆 Yes	2 🗆 No				
Division of Vital	r Atte	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, s	treet, factory	y, office		28f. Location (S City or Tow	Street and Numbe m, State)	r or Rura	I Route Number,
	itel or irs afte ral Dir	O										and the second
	To the Hospitel or Attenviction 24 hours after deatle To the Funeral Director: completely filled in by the	dical	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, dea ation and/or i	ith occurred nvestigation	at the time, da , in my opinior	ate and place n, death occu	rred at the time,	date and place, a	ner as si nd due to	the cause(s)
	thin 2	Med	29b. Signature and title of certifier	and marrier states.		290	c. License nun	mber		29d. Date signed	(Month,	Day, Year)
	viil Cor						DE	570	2-8	02-	25.	-04
,			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	e, Print)	/21====			-		
			ADITYA CHOPRA	, md. 600 k	UDGEL	-Y AI	IESTE?	231 A	NAPOL	15,m	<b>D</b> .	21401
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DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:55 AM **Physician** Amos Irvin Hostetter February 29 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Months Min Year) 1919 Hours 15 M 2□F Maryland 84 220-18-2307 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD. Hagerstown Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21742 20530 Millers Church Rd. death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I sent: If Item 27 is marked or Minnie G. Showalter Henry H. Hostetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20530 Millers Church Rd. Hagerstown, Md. 21742 Ethel S. Hostetter/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If Ite any injury or ot cometery crematory or other place)
Millers Mennonite
Church Cemetery 1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/4/04 Leitersburg, Md. permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee once. Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition eumpua **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of) by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year ŏ in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, should be dereure 1 🗌 Yes 2.☐No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed has director, page 2: certificate 1 ☐ Yes 2 1 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) EFT-FRIM BUD SMITHSBURY, MID 31. Date filed (Month, Day, Year) State 10 Registrar

	1	For State Registrar	State	of Maryland		rtificate of E			eg. No. 🤈	001	070
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Physician		WILLIAM RALPH	JONES SR	•				Month FEBRUARY	Day 7 19, 2	Year 2004	8:56 P
/Medica Examine		a. Facility Name (If not institution		ımber)		4b. City, Town, or	Location of Deat			y of Death	
		8678 SWAN HAV	EN ROAD			EASTON				BOT	
uneral	5	. Social Security Number	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)	9. Birthr	place (State or For htry)
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of a bo	ō	MD Tal	bot	Eas	ton						1 ☐ Yes 2 🂢
28a-	0	0e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
Sa or	<u> </u>	8678 Swann Hav	en Road			21601	1		U.S.	.A.	
ms 2:	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.S	5. 13.	Was Decedent of His	spanic Origin? (S	Specify Yes or No-		ce - Americ	
or Ite	Ξ	1 ☐ Never Married 2 🔀 Ma		2 🗌 No		If Yes, specify Cubar 1 ☐ Yes 2 X No	Specify:	to rican, etc./		ack, White, ify: Wh:	
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Mental Hygie harked other I hatic event, E	ă	17. Father's Name <i>(First, Middl</i> e Ralph Jones	, Last)					ired (unk		,,,,,	
narke natic	ဥ	19a. Informant's Name/Relation	ship (Type Print)		10b Mailie	ng Address (Street a		•		State Zir	Code)
7 is n Traun		Julie M. Jones				Swann Have					, 0000)
Health tem 27 other tr	-	20a. Method of Disposition	, , , , , ,	20b. Pia	ace of Dispo	osition (Name of	1		20c. Location		own, State
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	e.	Sequentially list conditions, if any, leading to immediate		o (or as a consequ							
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		1	State of Maryland / Depa	artment of Health and Martificate of Death	lental Hygien	- 7 H H H H M 7 2 2 E
			Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year
	Physicia /Medic		Clarence Michael Jordan		February 2	22, 2004 /74 / M
	Examin	· .	4a. Fecility Neme (If not institution, give street and number)	4b. City, Town, or Location of Deeth	4	c. County of Death
			936 Bay Ridge Ave.	Annapolis		nne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  1 ☑ M 2 ☐ F  Yrs.	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	
	Director	-	212-54-9029 54		July, 25 19	949 Maryland
	and and	-	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Many 1 sho	ō	Maryland Anne Arundel Annapolis			1 🛱 Yes 2 🗆 No
	288.	Directo	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	3a or		936 Bay Ridge Ave Apt 301	21403	Uni	ted States
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or its	T	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No Specify:	,	Specify: White
200	within 72 hours after death with the Maryland piece. Than "natural", or Itams 23a or 28a-f show the Madical Examiner coast be notified at	d by		Λ	401	
'n	72 h natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		Kind of Business/Industry
[2]	Mithin then	ם	Elementary/Secondary (0-12) College (1-4or 5+)		Con	nstruction
N	s filed within 72 I Hygiene. other than "nat rent, It's Medic		17. Father's Name (First, Middle, Last)	Employed  18. Mother's Name	e (First, Middle, Maide	en Sumame)
ano	d la b	) Be	Clarence Jordan, Jr.	Margaret		
Maryland 21215-0036	s 1 and 2 should be of Health and Menta liem 27 is marked other traumatic events.	2	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code)
	and 2 sealth ar m 27 is ner trau		Jesse Jordan / Son 934 B	ay Ridge Ave. Apt	304 Anna	apolis, MD 21403
ē,	r Heal Heal		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	0 0	l	1 Burial 2 KiCremation 3 Li Hemovai from State		'2004 Bal	timore, Maryland
a E	그 문문을					lor Funeral Home, Inc.
Ö	Deparement of the policy of th					Annapolis, MD 21401
	70 KG		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause op each line.	en .	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Ation		Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
120	Examiner		Sequentially list conditions. b. HANGING	7		
	sit sd	Examiner	Sequentially list conditions, if any, leading to in Trodiate cause. Enter Underlying			
	and -trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760,	te be executed ysicien and te burial-transit	calE				
687			d			
× e	ding se as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten atten for u	clan	in the past 12 months?  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
o.	that the death ed by the atte detached for	ysl	1 Yes 2 No 9 Unknown			
<u>α</u>	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death?
rds	n sign				1 🗆 Yes	2 No 3 Probably 4 □Unknown
Records,	aw requir as been s 2 should	lete			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	The lavate has	Completed			performed?	? death?
Vital		Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
>	Physician: this certific ral director,	ToE	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing He	ome 5 Residence	6 ☐ Other (Specify)
J Of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yeer) Injury	Work?	28d. Describe how in	injury occurred
Ö	Attending r death. sctor: After by the fune	atlc	2 ☐ Accident investigation 2/21/EU U™	K M 1 □ Yes 2 K No	HUP.	
Division	f or Attendater death	Certification:	4 Homicide determined building, etc. (Specify)	treet, factory, office	Gity or Town, Sta	
	ital or ral D		Hom-e		ANNA	6,990
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier  (Check only one)  2 Medical Exeminer: On the basis of examination and/or in the basis of examination and	ith occurred at the time, date and place, nvestigation, in my opinion, death occu	red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the othe	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	F 3 F 8		Villen a dos mo	D0605	4	2/25/4
•			30. Name and address of person who completed ause of death (Item 23a) (Type	a, Print)		
			Milliam P. JONES, MD	695 Ameri	CA 2	1035
**	St	ate	31 Date filed (Month Day Year) 32 Redistrar's Signature			
	Regist		FEB 2 6 2004	A CONTRACTOR OF THE PARTY OF TH		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

ELIZABETH

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be ex

	1-	State Registrar						Cen	tificate	of	Death	)		Reg.	No. ZU	UL	0/336
	1. 0	ecedent's Nam	e (First, Middle	e, Last)							_		2. Date of	Death	_	Year	3. Time of Death
/sician ledical	E	LIZABET	TH WASH	INGTON R	IDLEY	Ž.							FEBRU		2320		1822 M
aminer	4a.	Facility Name (	If not institution	n, give street and i					4b. City, 1	own, o	r Location	of Death			4c. County		
	-	THE	memo	KINL ,	4051	Pitt	7/		Di	510	N				TAL	B07	
eral ctor		ocial Security N 6-10-62		6. Sex 1 ☐ M 2 🛣 F		(In yrs. 91		hday) Yrs.	If Under Months	Year Days	If Unde Hours	Min.	8. Date of (Month) NOV 2	Birth Day, Ye		9. Birth	plece (State or Foreign ntry) JERSEY
одсе. To Be Completed by Funeral Director	-	el Residence o	f Decedent 10b. County			10c Cit	Tour	05100	ation								404 (
tor	104	MD		ALBOT		10c. Cit	ASTO		alion								10d. Inside City Limits  1 □ Yes 2 □ No
Director	10e	. Street and Nu	mber						10f. Zip	Code				10g.	Citizen of W	hat Cou	ntry?
	7	00 PORT	r st. #	212						216	501				U	SA	
Funerai		Marital Status		12. Was De	ecedent E Forces?	ver in U.	S.	13. W	as Decede	nt of H	lispanic Or	rigin? (Sp	ecify Yes or Rican, etc.)	No-		- Ameri	can Indian,
by		1X Never Marr 3 ☐ Widowed			s 2 <b>X</b> ∑Ni Give	0			☐Yes 2	_	Specify		riioari, oto.,		Specify:		ITE
ted		(Spa	15. Decedent	t's Education	d)		16a.	Decede	ent's Usual	Occup	ation	et of work	ina	16b	. Kind of Bus	siness/In	idustry
pie	E	lementary/Seco			(1-4or 5-	<b>-</b> )		life. D	O NOT use	retired	d)	SI DI WOIK	n ig				
Completed		12		0			R	ELAT	CIONS	OFF	FICE			U	7.S. G	OVER	NMENT
Be	17.	Father's Name													len Sumame	a)	
2		GEORGE											NE WAS				
				hip (Type, Print)											y or Town, S	State, Zip	Code)
		IRISTINI . Method of Dis		DLEY/SIS	TER	20h P			ORT Station (Nam		#212		CON, M		601 Location - 0	Sibr or Tr	our Ctata
		1 Burial 2	Cremation	3 Removal fro	m State	C	emeter	y, crem	atory or oth	er plac	, 1			1			
	_	4 Donation				CH	ESAL	-					2-25-2	2004	STEVE	NSVI	LLE, MD
	21.	Signature of Fu	. 21	Ostrur	li c	21.5	SP.	FEI		, HE	<b>ELFEN</b>	BEIN			FUNER 2160		OME P.A.
	23	a. Part1. Enter t shock, or hea	he disease, or art failure. List	complications that	t caused to	the death	h. Do n	ot ente	r the mode	of dyin	g, such as	cardiac o	or respirator	y arrest.			Approximate Interval Between
		nediate Cause ease or condition		Pn	enn	100	6										Onset and Death
		ulting in death)		-	o (or as a			of):/	Λ				. 0	\\			
	500	nuantially list as	aditions	1,50	psi	5 (	Wi	15	Ac	ert	CX	PN	alt	orto	100		
ner	if a	quentially list co ny, leading to in use. Enter Unde	nmediate	Due 1	(or as a	conseq	uence o	of):	~								
Examiner	tha	ise. Enter Unde use (Disease or t initiated events	S	a. DU	Imo	200	-8	h	0315								
	res	ulting in death)	Last	Que t	o (or as a	consequ	uence o	of):			1	A	-				
Medical				Cd. Cl	ronc	~ C	YS	me	ctu		lune	50	150	9 SC			
-		EMALE:		23c. If yes, o	utcome o	f pregna	incv										
ian	238	<ul> <li>Was deceden in the past 12</li> </ul>	months?	1□Live	birth 2	Fetal	I death		Ectopic pre						23d. Date Mont		ery Day Year
Physician		1 ☐ Yes 2 ( 9 ☐ Unknown		9□ Unl		ane or de	eatt1	2 🗀	Other (spe	uny)				_			
	Par	II. Other signi	ficant condition	ns contributing to	death but	t not resu	ulting in	the und	derlying car	use give	en in Part I	l.	23e. D	id tobacc	o use contri	oute to th	ne cause of death?
d by													1-	Yes	2 □ No 3	B □ Prob	ably 4 Unknown
Completed													240 14		045 144		- diadia-
d L													24a. W	nas an utopsy erformed:	pr	ere auto ior to coi ath?	psy findings available mpletion of cause of
-													1□ Ye		No 1		2 🗆 No
Be	25.	Was case refer examiner?		Hospital:						Oth		e of Death	(Check on	ly one)			
10	07	1 Yes 2		1,1	Inpatien		ER/Out				4 🗀 140				6 □Other		y)
on	27.	Manner of Deat	5 Pendin	g (Mi	e of Injury onth, Day	Year)	28b. Ti	ime of		C. Injury Work	k?		28d. Descri	oe how in	jury occurre	d	
cat		2 Accident 3 Suicide	investig 6 ☐ Could r	notho					М		Yes 2 🗆		201	10.			
Certification:		4 Homicide	determ	100d 208, Pla	ding, etc.	(Specify	ome, tar y)	m, stree	et, factory.	office				n (Street Town, Sta		ror Rura	I Route Number,
Medical (	29:	a. Certifier (Check only one)	Certifyin 2 Medical	g Physician: To t Examiner: On the and ma	he best of basis of e anner state	examinat	wledge, tion and	death Vor inve	occurred a estigation, i	the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to t ed at the tin	he cause ne, date a	(s) and man and place, ar	ner as st	lated. the cause(s)
Me	29t	. Signature and	title of certifier						29c.	License	e number			29d. [	Date signed	(Month,	Dey, Year)
		1/	Sal	1/1	M	$\supset$			D	00	597	760	)	6	2/2	41	04
	30.	Name and addr	ress of person	who completed ca	use of de	arth (Item	1 23a) (	Type. P		, ,-	/			1		/ (	
	-	17	TINDA	/ <n< td=""><td>MY</td><td>7</td><td>m</td><td>1</td><td></td><td>9 6</td><td>MAC</td><td>HTNC</td><td>מסת פיי</td><td>ለ ፕሮ</td><td>STON,</td><td>мп</td><td>21601</td></n<>	MY	7	m	1		9 6	MAC	HTNC	מסת פיי	ለ ፕሮ	STON,	мп	21601
State	31.	Date filed (Mon	th. Dav. Year)	- 32	Registrar	's Signa	ture		) 41	, 0.	WALD	TITING.	TON 91	L. LLA	MINTON,	LID	21001

State Registrar

			1 - For State Registrar	State of Mary		artment of H rtificate of L	Death	Reg	ne .No.2004	
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las Robert C. Kel  4e. Fecility Name (If not institution, give	ler			Location of Death	2. Date of Death Month	Day Yeer 3 - 04 4c. County of Deet	
	Funeral Director		5. Social Security Number 6. Se 234-14-2367 15		yrs. last birthday) 85 Yrs.		If Under 24 Hrs. Hours Min.		ALLEGA 9. Birth 1918 Mar	
	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show than 'natural', or items 2a or 28a-f show the Maritinal Examinat must be notified at	ector	10a. State 10b. County MD Allegan  10e. Street and Number		c. City, Town or Lo JaVale			100	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√ No
	death with t ms 23s or 2 cmust be n	Funeral Director	300 National H.	12. Was Decedent Ever		10f. Zip Code 215 Was Decedent of Hi	02 ispanic Origin? (Spe n, Mexican, Puerto F		U.S.A.	rican Indian,
0036	hours after tural, or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced		WII		Specify:		Black, White Specify: W	hite
21215-0036	ed within 72 rgiene. er than *nal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th.	College (1-4or 5+)	(Give	o kind of work done of DO NOT use retired r/Operat	during most of working O  O  O  O  O  O  O  O  O  O  O  O  O	He P.	eating a lumbing	nd
0	buld be file Mentat Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last)  John R. Kell  19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street		Klincke		ip Code)
	es 1 and 2 shool of Health and of Health and if item 27 is more other treum.		Ruth M. Keller  20a. Method of Disposition  1 Burial XX cremation 3 □	(Wife)	300	Nationa	l Highwa	y, LaVa	le, Mary	land21502 Fown, State
Baltimore,	permit. Pages Department of I Important: If iti any injury or o once.		*4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen:		2	2. Name and Addres		3	umberlan l Jones	
200	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the one cause on each line.  a. Sepsi of Due to (or as a co		ter the mode of dyin.	g, such as cardiac or			Approximate Interval Between Onset and Death 2 days
8760,	ite be executed ysician and he burial-transit	licai Examiner	Sequentially list conditions, if any, facing to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co						
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phiral director, page 2 should be detached for use as it.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delin	very Day Year
Ś	w requires that been signed b should be deta		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	inderlying cause give	en in Part I.		cco use contribute to	
Vital Record	n: The law r ficate has be r. page 2 sh	Completed							prior to c	topsy findings available ompletion of cause of
<b>\F</b>	s certi	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 X Inpatient	2 ER/Outpatie	nt 3 DOA Othe	26. Place of Death er: 4 □ Nursing Hom		e 6 □Other (Spec	ifu)
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification; T	27. Manner of Death  1 Manual 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	of 28c. Injury Work M 1 🗆	y at 2 ⟨? Yes 2 □ No	8d. Describe how	injury occurred	
Divi	Hospital or Att 24 hours after d Funeret Direct tely filled in by t		4 Homicide determined	28e. Place of Injury building, etc. (S	ipecify)			City or Town, S		
	Hos 124 hos na Fun Hetely	edicai	(Check only 2 Medical Examone)	iner: On the basis of exa and manner stated.	mination and/or in	ivestigation, in my of	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier  Wonscepsor	hir MD		29c. License	55325		Peb 14	-
3-7	NH_		30. Name and address of person who or WON30CK SHIN M	D 48 Taz	m Terro		House M	D 2153	2_,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	oignature	AP - 0	O			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001

07338

							Ce	rtificate (	of L	Death			Reg. No.		-	
			1. Decedent's Name (Firs.	, Middle, Last)								2. Dete of D Month	eath Day	Voor	3. Tin	ne of Death
	Physic: /Medi		Anna Doreen	Kersch	enste	iner						Februa	ry 20,	2004	10	:25 PM
	Exami		4e. Facility Name (If not in Goodwill Mer						4	•	wn, or Lo	cation of Dea	th 4c. Cou	nty of Death		
	Funeral	Г	5. Social Security Number	6. Sex		, ,	yrs. last birthday,			If Under		8. Date of B	irth	9. Birth	olace (St	ate or Foreigi
	Director		191-28-4766 Usual Residence of Dece		M 2⊠F	95	Yrs.	Months Da	ays	Hours	Min.	Mar 7	, 1908	Penr	nsylv	vania
	Maryland f show	٥	19.55	County arrett			c. City, Town or L Grantsvi									de City Limits Yes 2 No
	the 128a-	Director	10e, Street and Number					10f. Zip Cod	de				10g. Citizen	of What Cou	ntry?	
	Mar or	Ö	891 Dorsey 1	lotel R	oad				536	5			-	JSA	,	
	ter death itams 2: iner mus	era	11. Marital Status		2. Was Dec	cedent Ever	in U,S. 13.	Was Decedent		_	gin? (Spe	ecify Yes or N		Race - Americ	can India	n,
0700-61717	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or itams 23a or 28a-f show event, the Mydical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ D		Armed F 1 ☐ Yes If Yes, G Year or I	2 🗓 No live		If Yes, specify ( 1 ☐ Yes 2 🙀		Specify:	i, Puerto	Rican, etc.)		Black, White, c <i>if</i> whit		
5	2 hou	Completed	15. D	ecedent's Educ	ation		16a. Dece	dent's Usual O	ccupa	ition		•	16b. Kind o	Business/In	dustry	
2	hin 7 in 17	ple	(Specify only Elementary/Secondary	highest grade		(1-4or 5+)	(Give	kind of work do DO NOT use re	one d etired)	u <i>ring</i> mosi )	t of worki	ing				
7	should be filed with nd Mental Hygiene. msrkad other than imatic event, the M	E O	8 th	0-12)	College	(1-40/ 54)	Home	naker					Own	Home		
2	othe /ent,	Be C	17. Father's Name (First, I	Aiddle, Lest)						18. Mothe	r's Name	e (First, Middle	e, Maiden Sun			
Maryland	Ald but Menta Kad	To B	Silas Hoste	ler						Meli	nda	Folk				
<u> </u>	d 2 should be f th and Mental f 7 is msrkad of traumatic eve		19a. Informant's Name/Re	lationship (Typ	e, Print)		19b. Maili	ng Address (St	reet a	and Numbe	er or Rura	al Route Numi	ber, City or To	vn, State, Zip	Code)	
			Shirley Ludy	//daugh	ter		1152	Glenco	e F	Road,	Fai	rhope,	PA 15	5538		
ָט ב	iges 1 and 2 it of Health if item 27 is or other tre		20a. Method of Disposition				0b. Place of Dispo	osition (Name o	of nlace	a)		Date	20c. Locatio	n - City or To	own, Stat	е
2	Page ent o nt: If i		1 Ma Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ O		emoval from	State	Glade Ce	•	piace		24	2004	Berli	n, PA		
Dalillore,	permit, Pages Department of I Important: If ite any injury or of once.		21. Signature of Funeral S		е	0	2	2. Name and Ad ewman F	ddres UNG	s of Facilit	v		., PO I	30x 27	5	
			Note	c v je	un	llev		79 Mill						2153	5 /	
			23a. Part1. Enter the dise shock, or heart fallur	ase, or complice. List only one	ations that e cause on	caused the each line.	death. Do not en	ter the mode of	dying	, such as	cardiac c	or respiratory	arrest,		Approxi	Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a.	En	d 5	tage to (or according to Version Versi	Dim	ne,	nti	å			1	Onset	and Death
	cuted Id	Examiner	Secure distincted constitutes	<b>C</b> b.	Cer	reb	ral V	Ces CC	il	ar	a	ccu	der	1		
Š	an ar	Ě	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	e	As	THI	nA	,,								
00/00	ysicii ne bu	ical	that initiated events	c.	110	Due	to (or as a consec	uence of):								
9	certificate be executed nding physician and use as the burial-transit	n/Medical	resulting in death) Last	L.			,	,						j		
	th cer tendin r use	an/		d.												
0	death deatte ed for	sici	Part II. Other significent c	onditions cont	ributing to d	eath but no	t resulting in the u	nderlying cause	e give	n in Part I.		23b. Did	tobecco use	contribute to	the ceu	se of deeth
ر. 5	The law requires that the death ate has been signed by the atter page 2 should be detached for r	by Physicia										1	Yes 2□N	3 ☐ Prol	bably	4 🗌 Unknow
DIVISION OF VITAL RECORDS,	w requires been sign should be											24a. Was	s an autopsy ormed?	av	ailable pr mpletion	osy findings rior to of cause
ב ב	The law ate has page 2:	Completed										1□	Yes 2∭XNo		death? ∃Yes	2□ No
g		0	25. Was case referred to r	nedical						26 Place	of Death	(Check only				
>	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 2 No		ospital:	Innatient	2 ☐ ER/Outpatie	nt 3□ DOA	Othe				idence 6 □0	ther /Specif	v)	
5	rthis eral c	Ė	27. Manner of Death			of Injury oth, Day Yea		-	Injury				how injury occ		<b>y</b> )	
5	ding th. Afte	tio		Pending investigation	(Mor	nth, Day Yea	ar) Injury			? ′es 2 🗆 1	No					
JVI3	or Atten after dea Director in by the	Certification:		Could not be determined	28e. Place build	e of Injury - ling, etc. (Sp	At home, farm, str decify)	eet, factory, off	ice		:		(Street and Nu wn, State)	mber or Rura	I Route I	Vum <i>ber</i> ,
	he Hospital or Attending Pi in 24 hours after death. he Funeral Director: After it pletely filled in by the funera	edical C	29a. Certifier 1 C (Check only one)	ertifying Physi edical Examin	er: On the b	e best of my pasis of exar	knowledge, deatl mination and/or in	n occurred at th vestigation, in n	e time	e, date and inion, deat	d place, a	and due to the	cause(s) and date and plac	manner as s e, and due to	tated.	se(s)
	To the within 2 To the comple	Me	29b. Signature and title of	certifier	1	7	5)			number	7 72		29d. Date sig		-	ır)
			25-0	_ /	m	EU/			U	242	- D	1	Feb 20	, 2002	ż	
			30. Name and address of								45	01505				
			Robin Bisse.	Veer	., 12	4 Mill Registrar's S		Grants	vil	le, l	MD	21536				
	Sta Registr		31. Date filed (Month, Day	3 2 4 21	104	iogistidi's S	1.0	A 10 -								
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)		•	for State Registrar				C	e	rtificate of L	Death		R	eg. No.	104	0733	4
94	* _	ė	1. Decedent's Name	First, Middl	e, Last)						2.	Date of Deat Month	h Day_	Year	3. Time of Death	
1 mg	Physici /Medic		Carro1	1 E.	Lippy						F	'ebruar	y 19,	2004	0540 P	M
ik.	Examir	100	4a. Facility Name (I		-	number)			4b. City, Town, or		eath			nty of Death	1	
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0	Funeral Director		219-68-93		1⊠M 2□F	_	44 · Yrs		Months Days			Date of Birth (Month, Day, 11v 18		Cou	vland	gn
	e e		Usual Residence of				77				D.C.	11y/10	1939	riai	yrand	
	inylan ihow	_	10a. State	10b. County			10c. City, Town o	r Lo	cation						10d. Inside City Limit	
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	with the	급	10e. Street and Nur			1			10f. Zip Code	c <b>-</b> 7		1	0g. Citizen o		•	
	eath	era	12019 Leg	gore br	12. Was De		ver in U.S.	13. \	217 Was Decedent of Hi		(Specify	Yes or No-	Unite		tes ican Indian,	
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene. ortent: if item 27 is marked other than "natural", or items 23a or 28e-f show injury or other treumatic event, the Medical Example Luist De craftled at injury or other treumatic event, the Medical Example Luist De craftled at 8.	by Funeral Director	1 Never Marri		ried Armed	Forces? s 2 ⊠No	0.0.0		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2☑ No	Specify:	ierto Ric	an, etc.)		lack, White		
0-10	2 hou	ted	/Pnos		it's Education st grade complete	d)	16a. De	9000	dent's Usual Occupa	ation	working		16b. Kind of	Business/li	ndustry	
218	ithin 7 ie.	Completed by	Elementary/Seco		7	(1-4or 5+	·) //ii	0.	DO NOT use retired	)	working					
21	led w lygier her th		12		( ant)		Cr	·er	w Leader	18. Mother's N	Name (F	Sent Middle I		Compa	ny	
and	I be fi	Be	17. Father's Name Paul Ed									usheri		ame)		
2	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "I freumatic event, the Med	2	19a, Informant's Na		110		19b. M	ailir	ng Address (Street a					m. State. Zi	p Code)	
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ē,	of Health of Health litem 27 i		20a. Method of Disp	position			20b. Place of D	spo			Date		20c. Location			
Ę	Pages nent of I int: If it		1 ☐ Burial 2 ! • 4 ☐ Demation		3 □Removal fro Specify)	m State			Cremator		Jiua	2004 1	reder	ick,	Maryland	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of	Service	Licensee				2. Name and Address		tauf	fer Fu	ineral	Home	s, P.A.	
Ω	88 5 8	4		2	1			16	21 Opossu	ımtown 1	Pike	Fred	erick,		land 2170	2
<b>\</b>	Physician /Medical Examiner	Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list confianty, leading to include Cause. Enter Under Cause (Disease or that initiated events	(Final on militions, more diagonal or militions, militions or milition	a	to (or as a	consequence of)	el	er the mode of dyin	ol y f	C.				Onset and Death	
68760,	eath certificate be executed attending physician and for use as the burial-transit	cal	resulting in death)	Last	Due d.	to (or as a	consequence of):									
O. Box	death e atter id for u	Physiclan/Medl	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[ 9 Unknown	months? □No		e birth 2 egnant at t	of pregnancy ! ☐ Fetal death ime of death		Ectopic pregnancy Other (specify)					Date of delin	very Day Year	
rds, P.	ob ob	þ	Part II. Other signit	ficant conditi	ons contributing to	death but	t not resulting in th	1 <del>0</del> U	nderlying cause give	en in Part I.			oacco use co es 2 □ No		the cause of death?	vn
Il Records,	The law requir ate has been si page 2 should I	Completed										24a. Was a autops perform	y		opsy findings availab ompletion of cause of 2 \( \subseteq \text{No} \)	
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case refer examiner?		Hospital:				Oth	26. Place of D				/		
of	Phys this al dir	10 10	1XXYes 2 ☐ 27. Manner of Deat		N					4   Nursing		5 Reside			ify)	
S C	ding h. After fune	tlon	1 Natural	5 🗌 Pendi	ng (M	te of Injury lonth, Day	101		f 28c. Injury Work		200	Sebuc'	- The	sel	*	
Division	for Attending after death. Director: After	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could detern	not be 28e. Pla		Y - At home, farm (Specify)	, str	reet, factory, office	7	28f.	Location (St City or Town	reet and Nut		al Route Number,	92
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)	1☐ Certifyi	Examiner: On the	the best of a basis of a anner stat	examination and/o	leati or in	h occurred at the tim vestigation, in my op	e, date and pla pinion, death or	ace, and	due to the ca at the time, d	ause(s) and place	manner as e, and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and	title of certific	ər	11.	,		29c. License	number		2	9d. Date sign	ned (Month	Day, Year)	
			171	well	ell.	6	2 mar	_	O.C.N	1.E.		F	'ebrua:	ry 20,	, 2004	
	12		30. Name and add	ress of person		ause of 6			Print) reet, Balt	imore,	Mar	yland	21201			
	Sta		31. Date filed (Mor	ith, Day Year	2 3 2004	. Regist	's Signature		1							_
	Regist	ar		· ED	2 3 2004	1	Marca D		Sparker!							

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		epartm <i>Certific</i>			d Men		giene Z () Reg. No.	104	0/340
			1. Decedent's Name (First, Middle, Las	t)						Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medi		John Robe	ert le	evis					2		2004	00:25 M
17	Examir		4a. Facility Name (If not institution, give	street and number)		4b. 0	ity, Town, o	r Location of D	Death		4c. County		
			Anne Annold	medical (	Centu	1.	mar	polis			Anne	An	ndel
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birti	hday) If U	nder 1 Year hs Days	If Under 24 Hours M	Hrs. 8. (	Date of Birth	Year)	Coui	place (State or Foreign
	Director		166-22-6516	<b>©</b> MM 2□ F	75 Y	rs.	lis buy s	TIOUIO	Oc	t. 17	, 1928	Pen	nsylvania
	9		Usual Residence of Decedent										Od. Inside City Limits
	how	_	10a. State 10b. County		10c. City, Town	or Location							1 ☐ Yes 2/2 No
	9 Ma	ct	Maryland Anne A	rundel				napolis					
	or 24	Oire	10e. Street and Number			10f	Zip Code				10g. Citizen of V	What Cou	ntry?
	23a	Funeral Director	1039 Pinecrest Dr	ive				2140				J.S.A	
	ems ems	ne	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was D If Yes,	ecedent of H specify Cub	lispanic Origin an, Mexican, P	? (Specify Puerto Rica	Yes or No- in, etc.)	14. Had	e - Ameno ck, White,	can Indian, etc.
စ္တ	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show dical Examiner rust be nutified at	Ę,	1 Never Married 2000 Married	1√G¥es 2 □ N If Yes, Give Year or Dates:	0	1 □ Y€	s 2000No	Specify:			Specify	v: W	hite
ö	ural',	Completed by	3 Widowed 4 Divorced			December 1	JI O	ation			16b. Kind of B		
21215-0036	nat nat	ete	15. Decedent's Ed (Specify only highest gra		104.	Decedent's (Give kind of life. DO NO	work done	during most of	f working		100. Killa of Di	0311033/11	dustry
7	withir than	E G	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)	Civil		•			U.S. Go	vern	ment
N	lled y	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>		01111	DCI VC	,	Name (Fil		Maiden Suman		IIICI1C
Maryland	t be f	Be	Hugh Lewis					Jane 1	M. De	enton			
Ž	d Me d Me nark	ဥ	19a, Informant's Name/Relationship	Type Print)	19h	Mailing Add	ress (Street				r, City or Town,	State. Zin	Code)
<u>a</u>	12 sl h an 7 ls r traur		Eila Lewis/wife	ype, 1 mil)	l l	•	•	st Ann			-		•
e) O	l and lealt		20a. Method of Disposition		20b. Place of	Disposition	(Name of		Date		20c. Location -	City or To	own, State
ŏ	it of H		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	y, crematory	or other pla		26/20	104	Dollaimo	1	MD.
	tmen tant: tant:		'4 □Donation 5 □ Other (Specify		Baltin	_			26/20		Baltimo		
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Deparmen of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than 'natural', or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinator usi Le notified at once.		21. Signature of Funeral Service Lices	dil	les	147	Duke o	of Gloud	ceste	r St.			MD 21401
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused	the death. Do n	ot enter the	mode of dyi	ng, such as car	rdiac or re	spiratory ar	rest,		Approximate Interval Between
No. of	Physician		Immediate Cause (Final	× 1	ocordia	. 1 -	Inte	retin					2 clays
¥.	/Medical		disease or condition resulting in death)		consequence								20000
П	Examiner												
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):							
	icate be executed physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
ó	an ar rial-tı	Ex	resulting in death) Last	Due to (or as a	consequence	of):							
68760,	te be ysiciá e bu	edical	(	d									
<b>89</b>	iffica g ph as th												
Box	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 DEctor	ic pregnanc	v				te of deliv	
m	deatle e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			r (specify) _				Mo	onth	Day Year
<u>о</u> .	t the by th ache	hys	9 Unknown	9□ Unknown									
ر. ت	res that the de signed by the a i be detached f	by P	Part II. Other significent conditions of	ontributing to death bu	t not resulting in	the underly	<b>n</b> g cause giv	ven in Part I.		23e. Did to	bacco use con		he cause of death?
ğ	quire n sig uld b	be	metastatic o	nolos	cance	5			_	1 🗆 Y	res 2□No	3 Pro	bably 4 Unknown
၀	w require s been sign should b	Completed								24a. Was		Were auto	opsy findings available ompletion of cause of
Re	he lav e has age 2	m							_		rmed?	death?	
a	n: T ficat or. pa		25. Was case referred to medical					26. Place of	f Death (C		7	1 1 103	20110
5	sicia cert irecte	o Be	examiner?	Hospital: 1 Inpatier	nt 2 ER/Ou	tnationt 3	DOA Ott	hac			dence 6 Oth	ner (Speci	fv)
ot	Phy r this ral d	.: To	27. Manner of Death	28a. Date of Injur	y 28b. T	ime of	28c. Inju	ry at			now injury occur		
o D	ding h. Afte fune	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Ir	njury M	1 C	rk? ]Yes 2∐No	,				
S	deat deat ctor: y the	fica	3 Suicide 6 Could not b		ry - At home, fa	rm, street, fa	ctory, office		28f.			ber or Rur	al Route Number,
Division of Vital Records,	after Dire	ertification;	4 Homicide determined	building, etc						City or Tou	vn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	O	29a. Certifying Ph	ysicien: To the best of	of my knowledge	, death occu	rred at the ti	me, date and p	place, and	due to the	cause(s) and m	anner as s	stated.
	24 h Fur etely	Medical	(Check only 2 Medical Exer	niner: On the basis of and manner sta	examination and	d/or investiga	ation, in my	opinion, death	occurred a	at the time,	date and place,	and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifier	1			29c. Licen:	se number			29d. Date signe	ed (Month.	Day, Year)
	- s - 0		Munh	Lister	mo		Di	00601	76		2-73	-04	1
			30. Name and address of person who	completed cause of de	eath (Item 23a) (	Type, Print)					7 -0		
			Micah R. Fisher		^	indel	me	edical	Cer	Ner.	Annon	slis	Maryans
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature					-			4
			FFH Z 5	/11114	- A	ALC: NO	A 250.00						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004

			1 - State Registrar		Cei	tificate of L	Death	Reg	J. No.		
			1. Decedent's Name (First, Middle, I	ast)				2. Date of Death Month	Dav	Yeer	3. Time of Death
	Physici /Medio		Freda Vi	rginia M	oats			February	,	2004	10.55P M
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death	
			74 John DeWitt				akland				rett
	Funeral Director		5. Social Security Number 220-38-2366  Usuel Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 17,	1924		lace (State or Foreign try) yland
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	the Man 28a-f sh viffind	Funeral Director	MD G	arrett		Oak]	land	100	g. Citizen of V	What Coun	1 ☐ Yes 2 ☑ No
	3a or	ā	74 John DeWitt	Lane			21550		US		,.
	death ms 2	nera	11, Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		e - Americ	
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examenation until be modified.		1 ☐ Never Married 2 ☐ Married 3 ██Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Tes, specily cuba		o nican, etc.)		k, White, o	
5-0	72 ho	etec	15. Decedent's (Specify only highest)		(Give	ient's Usual Occupa	during most of wor	king 16	6b. Kind of Bu	siness/Ind	lustry
12	vithin han	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired					
7	iiled v Hygie ther t nt, th		12th 17. Father's Name (First, Middle, La	st)		Operat		ne (First, Middle, Ma			ocessing
Maryland	d be antal l	o Be	Freeman		Moats		Grace			ats	
2	Shoul nd Me mark	2	19a. Informant's Name/Relationship			ig Address (Street a		ral Route Number,			Code)
	nd 2 alth a 27 is r trau		Fayette G. Schr	ock/daughter	353	Audrev Ri	lev Road	l, Oakland	Md.	21550	0
re,	s 1 a of Hei item othe	1	20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of natory or other place			Oc. Location -		
E	Page nent c ont: M	- 20	1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	Hemoval from State		emeterv	. !	27/04	Auror	a. W	J
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service Lic			. Name and Addres	( P 12)	Stewart F			
<u> </u>	90 = 9	1 11	1 Stallent	- Llera				Oakland, M		50	
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each line.							Approximate Interval Between Onset and Death
П	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Complic  Due to (or as a consequ	atio	us of =	sidero	blusti	can.	lones	2 9915
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	0					0
п		Je.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	ience of):					-	
	nsit	min	cause. Enter Underlying Cause (Disease or injury								
<u>.</u>	execun and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):						
68760,	ertificate be executed ling physician and e as the burial-transit			d							
<b>68</b>	tifical ig phy as th	Medical	In arrive								
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	<u>-</u>		23d. Dat Mor	e of delive nth	ry Day Year
Δ,	that ted by deta	Y P	Part II. Other significant conditions	contributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contr	ribute to th	e cause of death?
rds	quires n sigr uld be	d b	Dialetes time I	543 taliz 1	cart	failure	2	1 ☐ Yes	2 No	3 🗌 Proba	ably 4 Unknown
Ş	s been	lete	01	/ / /				24a. Was an	24b. V	Vere autop	osy findings available
Vital Records,	ny <b>sician</b> : The law nis certificate has t I director, page 2 s	Completed						autopsy performe	ed? d	orior to con leath? ☐Yes	npletion of cause of
<u>ta</u>		Bec	25. Was case referred to medical				26. Place of Dea	th (Check only one)			
of <	Physician: this certific ral director.	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3□ DOA Othe	er: 4 Nursing H	ome Sesiden	ce 6 □Othe	er (Specify	)
0			27. Manner of De th 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at (?	28d. Describe how	injury occurr	ed	
<u>sio</u>	Attending ir death. ector: After by the fune	cati	Accident investigat 3 ☐ Suicide 6 ☐ Could not	he			res 2 □ No	-011			
Division	safter or at Direct of all Direct of in by	Certification:	4 Homicide determine	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,		er or Hural	Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tim restigation, in my op	ne, date and place, pinion, death occur	, and due to the cau rred at the time, date	se(s) and ma e and place, a	nner as stand due to	ated. the cause(s)
	To the vithir To the comp	Me	29b. Signature and title of certifier	~ [/		29c. License	number	290	d. Date signed	(Month, L	Day, Year)
			1 Christinis	akain	N	) D	26650	25	4251	200	24
	6		30. Name and address of person wh	o completed cause of death (Item	23а) (Туре,						1
	-		Margaret A. Ka			6, Oaklan	d, Md. 2	1550			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	a 9					

State of Maryland / Department of Health and Mental Hygiene 2001 07342 For State State Registrar AMEND ITEM #19a&l. PER INF G830 4/16 Cartificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Bernhard William Marten <u>11:58</u> P<sup>™</sup> 23, 2004 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Annapolis Arundel Medical Center Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ★M 2 🗆 F 399-10-8650 85 Director 12, 1918 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f ehow Examiner must be notified at 1⊠Yes 2 No Director Maryland Anne Arundel Arnold the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21012 U.S.A. 1621 Bald Eagle Road or Items 23e Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No 8 / 1941- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 5/1943 Specify: 3 XWidowed 4 □ Divorced "natural", Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Metropolitan f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Appropriations Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marten Lydia Schaller Helmuth 2 19a. Informant's Name/Relationship (Type, Print JAMES WILLIAMS /STEP-SON James Marton/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3666 WHISKEY BOTTOM ROAD, IAUREL MD. 20724
1621 Baid Eagle Road, Arnold, Maryland 2101 James 20b. Place of Disposition (Name of 20c. Location - City or Town, State Davidsonville, 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot once. cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial 2/25/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service kice Bowie, Maryland 20715 16000 Annapolis Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 11 RUXIA resulting in death) /Medical Due for as a consequence of): **Examiner** Lestrelative Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2. ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 TYes 2.☑No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1- Impatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1-Natural 5 Pending investigation within 24 hours after use.....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29b. Signature and title of certifier 29c. License number mo 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print medica Noons IM 31. Date filed (Month, Day, Year) egistrar's Signature State FEB 25 2004 Registrar

	LA	311
Division of Vital Records, P.O. Box 68760	or Attending Physician: The law requires that the death certificate be executed the death.	Director: After this certificate has been signed by the attending physicien and
Record	fhe law requi	le has been s
of Vital	hysician: 1	this certificat
Jivision (	or Attending P	Director: After

cian	1 - State Registrar AMEND ITEM #29d PER 1  1. Decedent's Name (First, Middle, Last)  ERNEST JAMES MO	RRTS		2. Date of Death Month FEB 28	Day Ye <i>ar</i> 2004	3. Time of Death $1:16P$
lical iner	4a. Facility Name (If not institution, give street and CIVISTA MEDICAL	number)	4b. City, Town, or Location of Death		4c. County of Dealh CHARLE	
ıl r	5. Social Security Number 212-28-6866  Usual Residence of Decedent	7. Age (In yrs. last birthda 81 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye MAY 2, 19	9. Birthpla Count MARY	ace (State or Forei y) LAND
ctor	10a. State 10b. County  MARYLAND CHARLES	10c. City, Town or	BEL ALTON		10	d. Inside City Limi 1 ☐ Yes 2√2 N
Dire	10e. Street and Number 9475 LAWNDALE STREE	т	10f. Zip Code 20611	10g.	Citizen of What Count U • S • A •	ry?
by Funeral Director	11. Marital Status  1 ▼Never Married 2 Married 1 ▼ Yes.	ecedent Ever in U.S. 1 Forces? is 2 th No Give T	3. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	tc.
Completed b	15. Decedent's Education (Specify only highest grade complete	nd) (Gi	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king 16b	BLA. Kind of Business/Indi	
Com	8	g (1-401 3+)	FARMER	(5)	FARMING	
Be	17. Father's Name (First, Middle, Last)  CLEVELAND MORRIS			ne (First, Middle, Maid JLINE DYS		
J.	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street and Number or Ru			Code)
	LILLIAN GOSS-CAREGI	VER P.C	BOX 115 BEL A		YLAND 20	611
	20a. Method of Disposition	aamatani a	sposition (Name of rematory or other place)	Date 20c.	. Location - City or Tov	m, State
	ty Burial 2 ☐ Cremation 3 ☐ Removal fro '4 ☐ Donation 5 ☐ Other (Specify)		IEM.GARDENS 3-5-	04 WA	LDORF, MA	RYLAND
	Michael O.	00479	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	ND 20646	,P.A.	
	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulling in death)	al cad sed the death. Do not on each line.	idia Death			Approximate Interval Between Onset and Death
lical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):	po thermia			* >4 hrs
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. II yes, 1 □ Lin 4 □ Pr 9 □ Ur		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery	y Day Year
b	Part II. Other significant conditions contributing to	o death but not resulting in the	e underlying cause given in Part I.		co use contribute to the	cause of death?
Completed	Properter Sin	Totals		24a. Was an autopsy performed	death?	pletion of cause
Be	25. Was compered to midical examinary:  Hospital:			th (Check only one)		
ation: To	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpat te of Injury fonth, Day Year) 28b. Time Injur	of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how in	6 □Other (Specify) njury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Pl	ace of Injury - Al home, larm, ilding, etc. (Specify)	street, factory, office	281. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
edical	(Check only 2 Medical Examiner: On th	the best of my knowledge, de basis of examination and/or anner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date a	and place, and due to t	he cause(s)
≥	29b. Signature and title of certifier	1	29c. License number  0 - 3 7 / 1		Date signe (Month, D LISUARY 28, 20	ay, Year)
	X John Cha	<del></del>		/	///	
	30. Name and address of person who completed of SONG C CHON MD 7 C			D 20602	_///	7

State of Maryland / Department of Health and Mental Hygiene 1 07344 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 23, 2004 7:15 Рм **Physician** Sue Scott McCann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Genesis Eldercare, Spa Creek Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Sept. 3, 1905 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F Mississippi Yrs 98 214-66-3852 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show iral', or items 23a or 28a-f show Examiner must be notified at Arnold Anne Arundel 1 Yes 2 No Maryland Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21012 U.S.A. 69 Church Road Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 Specify: White þ 3 Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be the Department of Health and Mental Pimportant: If item 27 is marked of any injury or othar traumatic ever Mary Grafton John Lee Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Silver Spring, MD 20904 1724 Featherwood St. Mary McCann/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2004 | Baltimore, MD 5 Other (Specify) Baltimore Crematory <sup>4</sup> □ Donation 21. Signatura / Funeral Sylice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Duce. 147 Duke of Gloucester Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between and D Is chemic Cardiony ipully Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as e consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. eų! detached 9 Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 eq 3 Probably 4 Unknown 1 Tyes 2 No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one. examiner Other: ursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13236 2/24/2007

di cause of death (Item 23a) (Type, Print)

HOP Admole Orion Charlos Mo 2/665

32. Argistrar's Signature on who completed cause of death (Item 23a) (Type, Print) (૭G~4 31. Date filed (Month, Day, State 2 Registrar

hysici		1. Decedent's Name (First, Middle,	Harry Dai	rclay Minor J	Jr.	2. Date of Month	Death	Day Year	3. Time of Death
Medic		Harry	Barkley Mi	nor, Jr		Febru		28 2004	1612 P
xamir		4a. Facility Name (If not institution,	•		4b. City, Town, or	Location of Death	4	4c. County of Deet	
		Washington Adv	<del>_</del>		Takoma			Montgom	
eral ctor			1MM 2015	e (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. 8. Date of (Month,	Birth Day, Yea		hplace (State or Fore
l		218-46-4355 Usual Residence of Decedent	55	) 115.		July	18, 19	948 Ma	ryland
		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limi
	lor	Maryland Prince	Georges	Hyattsv	1110				1⊠Yes 2□N
	rec	10e. Street and Number	Georges	llyactsv	10f. Zip Code		10g. (	Citizen of What Co	untry?
l	Funeral Director	6700 Belcrest R	oad, Apartm	ent 709	20782			United St	ates
	Jera	11. Marital Status	12. Was Decedent I			ispanic Origin? (Specify Yes or In, Mexican, Puerto Rican, etc.)		14. Race - Ame	rican Indian,
ļ	Ē	1 ☐ Never Married 2 💆 Marrie	Armed Forces?	40				Bleck, White	e, etc.
	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: B	lack
I	Completed	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occup	ation	16b.	Kind of Business/	Industry
	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+) Uner	DO NOT use retired	ation during most of working Insurance		ited Stat	
	Son		5	Clai	ms Invest	igator	De	partment	of Labor
	Be (	17 Eather's Name (First, Middle, L. Harry Barclay Mino	r Sr.			18. Mother's Name (First, Mid	dle, Maide	en Sumame)	
	2	Harry Barkley M	inor, Sr.			Mary Bernice	Simp	ers	
		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural Route Nu	mber, City	y or Town, State, Z	lip Code)
ı		Robin L. Minor/	Wife			Rd., A.t. 709,	Hya	ttsville	MD 20782
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Pamoual from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	March 4,	20c.	Location - City or	Town, State
		'4 ☐ Donation 5 ☐ Other (Spe		Providen	ce Cemete		E11	kton, Mar	Pacty
		21. Signature of Funeral Service Li	censee			es of Facility for Funerals,	D 7	NEOH) PEH	ATOM
		Donald	S. Hub	ν 1 <u>π</u>	O3 W. Sto	ckton Street,	P.A. Elkta	• on. Marvl	and 21921
ſ	0	23a. Part1. Enter the disease, or c	omplications that caused	the death. Do not en				on nary	Approximate
		shock, or heart failure. List of Immediate Cause (Final	ny one cause on each lin	MAG A	DEATING	11 10 6			Interval Between Onset and Death
		disease or condition resulting in death)	a. Chick	a consequence of):	LIVITTI	MIMS			
			COH	G-BLT1	VE HE	PART FAIL	()(	IF I	
1	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	V 3 1 1 4	7/001	- 0 1		
	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	MAI	1 GNA	VT	HVPFNTE	NO	MON	
	xa	that initiated events resulting in death) Last	Due to (or as	a consequence of):		711712	-11	01014	
ŀ	B								
	용		d						
	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of dali	
١	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
1-	Ž	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	or down	_ o.i.o. (apocity)		-		
-injun		Part II. Other significant condition	s contributing to death bu	ut not resulting in the L	Inderlying cause give	en in Part I. 23e. D.	d tobacco	use contribute to	the cause of death?
		@ CONFELTIVE	CANDION	NYODATI	TY 2 MORBI			/	bably 4 Unknow
The second secon	d by		7 101			v Oum			
		0 0 0 0	A-11 1 .	20-1-0		2 - 0 0: -		24b. Were au	topsy findings availab ompletion of cause of
				ADROME DI	UE TO MAS	SIVE OBESITY 24a. W	topsy	DINOI TO C	
١.			ATION SYR			SIVE OBESITY 24a. W au CNASY ALBU PO POPERSON 10 Ye	topsy rformed?	death?	2 No
	e Completed	(1) HYPE NCHOLL 25. Was case referred to medical	ESTEROLEN	NIAS)POSS	UE TO MAS	ANALYALTRUY DE	topsy normed? s 2 N	death?	2 No
	Completed	(1) HYPERCHOL		NAS POSS	UE TO MAS	26. Place of Death (Check on	topsy informed? s 2 N y one)	death?	
	To Be Completed	25. Was case referred to medical examiner? 1 Ses 2 No 27. Manper of Death	ESTEROLEN HOSDITAL	nt 2DER/Outpatier	UE TO MAS	26. Place of Death (Check on arr. 4   Nursing Home 5   Ri	topsy rformed? s 2 N y one)	death?	
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	To Be Completed	25. Was case referred to medical examiner?  1 yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1   Inpatie  28a. Date of Injur (Month, Day)	nt 2/2/ER/Outpatier  (Year)  28b. Time of Injury  ury - At home, farm, str	UR TO MAS  NORE COLL  ATY 3 DOA Other  28c. Injury Work  M 10	26. Place of Death (Check on arr. 4   Nursing Home 5   River 128d. Descrit 27   Ves 2   No	topsy informed?  s 2 N  y one)  esidence be how inj	death? 1  Yes  6  Other (Speciarry occurred	ify)
The state of the s	To Be Completed	25. Was case referred to medical examiner?  27. Manper of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	Hospital: 1   Inpatier  28a. Date of Injur (Month, Day	nt 2/2/ER/Outpatier  (Year)  28b. Time of Injury  ury - At home, farm, str	UR TO MAS  NORE COLL  ATY 3 DOA Other  28c. Injury Work  M 10	26. Place of Death (Check on arr. 4   Nursing Home 5   River 128d. Descrit 27   Ves 2   No	topsy informed? s 2 N y one) esidence se how inj	death? 1  Yes  6  Other (Speciarry occurred	ify)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MillER PUNATHAN 0457 AM FEBRUARY 28 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner he Johns Hopkins Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) BAHIMORE CI Baltimore 8. Date of Birth (Month, Day, Year) May 31, 1989 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2□F Hours Penna. 193-70-2302 14 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other than "natural", or Itams 23a or 28a-f shovent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Penna. Franklin Chambersburg Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4728 Molly Pitcher Hwy. South 17201 U.S.A. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after 1 □ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Education/Junior High 9 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental marked 27 is marked traumatic e Gregory I. Miller Tammy Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traces Tammy Miller/Mother 4728 Molly Pitcher Hwy. South Chambersburg, Pa.17201 20b. Place of Disposition (Name of cometery, crematory or other place)
Mercersburg Mennonite
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department Important: If eny injury or once. 3/3/04 Mercersburg, Pa. 21. Signature of Funeral Service Licensee Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. Zimmerman And Son Funeral Ho
45 S. Carlisle St. Greencast

23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) FIBROSIS Physician CYSTIC /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a por sectuance of Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PNEWMOTHERAX 1 Yes 2 No 3 Probably 4 Unknown Be Completed PANCERATIC INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy BRONCHOPLEUNAL FISTULA 2□ No 1 Yes 2 No 1 Tes Division of Vital o the Hospital of Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Cther 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) D0055659 MI 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE MID 600 North Wolfe ST. SCHWATZ MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** February 20,2004 8:20 A Mary Ε. Potts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot William Hill Manor Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 AF Months Yrs. 96 Feb. 12, 1908 Maryland Director 219-14-3621 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 No Funeral Directo Talbot Maryland Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1020 N. Washington St., Apt. 1303 21601 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 ₩Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) 4 Homemaker Some else's home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be item 27 is marked o Janie Howard Henry Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 N. Washington St., Apt. 1303, Easton, Md. 21601 Doris Potts / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ites
eny injury or ott 1 ■ Burial 2 □ Cremation 3 □ Removat from State \*4 ☐ Donation 5 ☐ Other (Specify) Paradise Cemetery 02/25/2004 Trappe, Maryland 21673 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 21. Signature of Funeral Service Licensee Muce 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dulake Keg mellmone Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2, ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peeu ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy After this certificate 1 Yes 1 Yes 2 No 2 No Hospitel or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury after death. 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours To the Funerel 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 William 30. Name and address of person who completed cause of death Item 23a) (Type, Print) William H. Wood, M.D.,506 Idlewild Ave., Easton, Maryland 21601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Maryland		artment of H tificate of D			en 200 L;	07348
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State of Maryland / Department of Health and Mental Hygiene 2001 07349 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Karen Michelle Peterson Feb<u>ruary</u> 17,2004 /Medical 6:21 4e. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RESERICK MENORIAL 10 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) **Funeral** Days Min. 1 M 2 F 114-48-4848 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natursi", or items 23a or 28a-f show other traumatic event, the Micinal Examinar must be notified at To Be Completed by Funeral Director 1 Yes 2 No REDERI FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL LIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) (son) 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 0 = 1 Surial 2 Cremation 3 Removal from State ò Department of important: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Consee 22. Name and Address of Facility GARY L. ROLLING FUNERAL HONE FRED. MO. ollen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Hospital: Inpatient Other: Certification: To 2 ER/Outpatient this 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Peath ate finjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who npleted cause of death (I)em 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

, ,		1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 2 1	NI 07350
Physic /Medi		Decedent's Name (First, Middle, L     WILLARD LACY	•				2. Date of De Month Februar	ath Day	Yeer 04 0225 P. M
Exami		4a. Facility Name (If not institution, g 19601 Barnesvil	,		4b. City, Town, or Dicke			4c. County	of Death
Funeral Director		579-36-9145	Sex 7. Age ( <i>In yr.</i> 75	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da JULY 3	th y, Year)	Birthplace (State or Foreign Country)     VA
death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD MONTO		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💢 No
ith with the 23s or 28s	Funeral Director	10e. Street and Number 19601 BARNESV	LLE ROAD		10f. Zip Code 20842			10g. Citizen of W	hat Country?
_ <u>``</u>	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Tyyes 2 No1 9 If Yes, Give Year or Dates: 1 9 5	46-	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	spanic Origin n, Mexican, F Specify:	? (Specify Yes or No- verto Rican, etc.)		- American Indian, K. White, etc. WHITE
21215-0036 d within 72 hours after jiene. r than "natural", or Ite	Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	ducation	16a. Deced (Give life.	lent's Usual Occupa kind of work done d DO NOT use retired, TAKER	luring most of	working	16b. Kind of Bus	iness/Industry
Maryland 2 d 2 should be filed th and Mental Hygi ? Is marked other traumatic event,	To Be Co	17. Father's Name (First, Middle, Las ROBERT FRANKI	•				Name (First, Middle,	Maiden Sumame	)
C = W =		·	DAUGHTER	3411	DRY PONI	nd Number o	GRANI	r, City or Town, S FE FALL	State, Zip Code) S NC 28630
Page Page ment o		20a. Method of Disposition  1 Ma Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Special Signature of Fundata Service Libe	Removal from State F(	OREST	OAK CEMI	ET. 2,	Date / 23/04		RSBURG, MD
Departit. Departit. Importations		23a. Pert 1. Enter the disease, or conspect of heart failure. List only	U	H	Name and Address  ILTON FU O BOX	JNERAI	L HOME BARNESVII	LLE, MD	20838
Pnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Suff grant  Due to (or as a conse	won		bade		est, ·	Approximate Interval Between Onset and Death
cate be executed scale be executed scale be executed scale and the burial-transit	al Examiner	Sequentially list conditions, # any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a sunsa c. Due to (or as a conse						
e death certificate attending to	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont	,
w requires that the been signed by (	by P	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause giver	n in Part I.	23e. Did to	5.0	ute to the cause of death?
ysician: The law r. ysician: The law r. is certificate has be director, page 2 sh.	Completed						24a. Was a autops perfori 1 Yes	sy pri med? de	ore autopsy findings available or to completion of cause of ath? Yes 2 □ No
ng Phys	ation: To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other	4 □ Nursin			(Specify)At scene
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	i Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		19601 Barn	n, State) PSV/UE R.d.	or Rural Route Number,
To the Hospital or within 24 hours aft to the Funeral Di completely filled in	Medicai	29a. Certifier (Check only one)  1 Certifying Pr 2 Medical Exam  29b. Signature and title of certifier	nysician: To the best of my knimer: On the basis of examinating and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opin	nion, death o	ccurred at the time, d	ate and place, and	er as stated d due to the cause(s)  Month, Day, Year)
F ≯ F 8	F	1 Zakill	las Ala	n 23a) (Tuna B	OCME		-	February	18, 2004
Stat	No.	30. Name and address of person who 2MS I M CL + V 31. Date filed (Month, Day, Year)	32. Registrar's Signa		111 Penr	Stree	et, Baltim	ore, Mar	yland 21201
Registra	ar	FEB 2 3	2004	A A	porte				

			For State Registrar	State of	f Maryla	•	artmen			and M	ental Hyg	jiene	) () i,	0735	5.1
	Physici		Donald H. Pe								2. Date of Dea Month Feb.		2004	3. Time of Dea	ath M
	/Medic Examin		4a. Facility Name (If not institution Anne Arundel	, give street and nu	mber)		4b. City,		Location o			4c. Cou	nty of Death		
	Funeral Director		5. Social Security Number 215–24–0413	6. Sex 1 <b>∑</b> M 2□ F	7. Age (In yr 76	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec. 6,	1927	9. Birthp Cour	lace (State or Fo try) MD	oreign
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel	10c. (	City, Town or Li		nold	l				1	0d. Inside City L 1 ☐ Yes 2√2	
	3e or 28s	al Direc	10e. Street and Number 816 Bradford A	venue			10f. Zip	Code 210	12			0g. Citizen o	of What Cour	itry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show says figury or other traumatic event, the Madical Examinar must be notified at ances.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marr  3 ☑ Widowed 4 □ Divorced	Armed F	2 □ No ve ta	u.s. 13. WWII Korea	Was Deced If Yes, spec		spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. R B	lace - Americ lack, White, cify: Wh		
21215-0036	d within 72 ho giene. or than "natur	Completed by	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12			(Give	dent's Usua kind of wor DO NOT us Steam	rk done d se retired,	luring most )	t of worki	ng		Business/Inc	d Yard	
Maryland	should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, William Peeple							r's Name a Mil	(First, Middle, ler	Maiden Sum	ame)		
	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relations. Donald Peeples			809	Buena	Vis		<i>r</i> enue	Route Number	d, MD	2101	2	
Baltimore,	Pages 1 ment of He ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S			Place of Dispo cometery, cre Metro (	matory or of	ther place	9)	Feb.	27		n-City or To		
Balt	permit. Page Department Important: II any injury or		21. Signature of Funeral Septical	Su									ark Fu ark, M	neral Ho 21146	ome o
	Pnysician /Medical	NY Y	23a. Part . Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a/s	er	1 Jon	ter the mode	e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Betwee Onset and Deat	
	Examiner	ler	Sequentially list conditions, I any, leading to ministrate cause. Enter Underlying	b	(or as a cons										
,092	ate be executed hysician and he burial-transit	cal Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last		(or as a cons	equence of):									<u>_</u>
.O. Box 687	The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ointh 2 ☐ Fe nant at time of	etal death 3	□Ectopic pro						Date of delive	ry Day Year	,
۵.	w requires that been signed b should be deta	by	Part II. Other significant condition	ens contributing to c	eath but not r	esulting in the u	anderlying ca	ause give	n in Part I.		23e. Did toi	1		e cause of death	
al Records,	sician: The law requiscentificate has been irector, page 2 should	Completed						· · · · · · · · · · · · · · · · · · ·			24a. Was a autops perfori	y	o. Were auto prior to cor death? 1 \( \text{Yes}	osy findings avai npletion of cause 2 No	slable e of
ion of Vital	ding Phy J. After this funeral d	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2  27. Manner of Death  1 Natural 5 Pendin 2 Accident investig		-	ER/Outpatier 28b. Time o Injury	-	8c. Injury Work	at □ Nu	rsing Hor	(Check only on ne 5 Reside 28d. Describe ho	ence 6 🗆 C		)	
Division	or At	Certification	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place	of Injury · At ing, etc. (Spe	home, farm, st	reet, factory	, office		4	28f. Location (SI City or Town		nber or Rura	Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the Examiner: On the t and mar	best of my k lasis of exami iner stated.	nowledge, deat nation and/or in	th occurred avestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the cased at the time, d	ause(s) and a ate and place	manner as st	ated. the cause(s)	
)	To t Com	Σ	29b. Signature and title of certifier	0860	bete	in	290	License	number	7	+32	9d. Date sign	ned (Month,	Day, Year)	1
			30. Name and address of person	who completed cau	se of death (It	em 23a) (Type,	Print)/6	7	of	en	50	Hu	9 7	may.	nd
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2	7 2004 32.5	legistrar's Sig	nature	food	6	V			/		1	

<b>Physic</b>		Decedent's Name (First, Middle, Last	State of Maryla 1,27,Per ME,0829,				2. Date of Death		3. Time of Dea
/Medi		Day	vid Charles Pu	ıgh			Febuary	29, 200	0313A.
Exami		4a. Facility Name (If not institution, give	·		4b. City, Town, or L	ocation of Death		4c. County of	Death
	(m. **	103 A Church Str	eet		Elkton			Cecil	
uneral irector		5. Social Security Number 6. S. 185–50–3813	ex 7. Age (In yrs ☑ M 2□ F 45	. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, ) JAN 25,	(ear)	Birthplace (State or For Country) Pennsylvania
show at at		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Lir
d other than "natural", or leams 23a or 28a-f shov event, the Medical Executive must be notified at	to	Maryland Cecil	ļ ,	Elkton					1 🛱 Yes 2 🗆
r 28g	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	at Country?
23a c	alD	103 A Church Stre	eet		21921			United	States
EL III	Funeral	11. Marital Status	12. Was Decedent Ever in I	J.S. 13. \	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe		14. Race -	American Indian,
a a	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 💆 No If Yes, Give			Specify:	noan, etc.)		White, etc.
le il	d by	3 Widowed 4 Divorced	Year or Dates:			оросну.		Specify:	White
nation	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occupati kind of work done du	on ring most of workir	16	6b. Kind of Busin	ness/Industry
then	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		po NOT use retired)			Consta	uation
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arked o	To Be	John R. Pugh				Helen F.		ison camano,	
item 27 is marke other traumatic	F	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailin	g Address (Street an			City or Town Sta	ite Zin Code)
27 ls r trau		Kathleen M. Pugh			Church St				
item 27 other tra		20a. Method of Disposition	20b	Place of Disnos	sition (Name of	n.	ate 20		y or Town, State
nt: If in y or o		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State Gi	Lpin Ma	natory or other place) anor Park	March	4,		
Important: If i any injury or once.		21. Signature of Funeral Service Licen:					E	ikton, l	Maryland
any ir		Daniel C	1.40	H:	Name and Address	for Fune	rals, P.	Α.	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dea	th. Do not ento	J3 W. SEOC	Such as cardiac or	eet, EIK	ton, Mai	ryland 2192
edical mud price in a paicie modernial-transit	cal Examiner	Sequentially list conditions, flary, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. One to (or as a consect of the to (or as a co	querice of):					
the attending ph hed for use as th	hysician/Medi	in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1	aldeath 3 death 5 death	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ac p	Ω	Part II. Other significant conditions co	entributing to death but not res	sulting in the un	derlying cause given	in Part I.			te to the cause of death
be	olet						24a. Was an autopsy performed	d? prior	e autopsy findings availa to/completion of cause he. Yes 2 \( \text{No} \)
cate has been sign page 2 should be	Completed					6. Place of Death			
cate has been sign page 2 should be	BeC	25. Was case referred to medical examiner?	Hospital:				e 5 🗆 Residenc		Specify) (scene
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irector: After this certificate has been sign: n by the funeral director, page 2 should be	To Be C	examiner? 1 ☑ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work? M 1 Yes	28 s 2 🗆 No	3d. Describe how	t and Number o	r Rural Route Number,
irector: After this certificate has been sign: n by the funeral director, page 2 should be	Certification; To Be C	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h	28b. Time of Injury ome, farm, stre	28c. Injury at Work? M 1 Tye:	s 2 \( \text{No} \)	Bd. Describe how Bf. Location (Stree City or Town, S	it and Number of	s an eleteral
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	ian	1 - State Registrament ITEM  1. Decedent's Name (First, Middle Millie	le, Last) Ga			Piper					2, Date of De Month FEBRUAR	Day		Year OO/	3. Time of			
/Medi Exami		4a. Fecility Name (If not institution				ipei	4b. City,	own, or	Location o		FEDRUAR		3, 2	004 of Death	1817	р		
LAUIIII		MEMORIAL HOSPI	-					BERL					LLEG					
uneral rector		5. Social Security Number 291-36-3550	6. Sex 1 □	M 20XF	7. Age (In yrs 62	. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir Month Da Jul 4,	† 19 <b>4</b> 1		9. Birthp Coup	lece (State or	Fore		
ad at	J.	Usuel Reside. a of Decedent  10a. State 10b. County  MD Alle		v	10c. C	Oldto								1	0d. Inside Cit			
be notifie	Direct	10e. Street and Number					10f. Zip		24555			10g. Citi						
must	eral	17610 Wagner		2. Was Dece	tent Ever in I	18 12	Mas Daged		21555		ait. Van aa Na		US		an Indian,			
other traumatic event, the Marital Examiner must be notified at	by Funeral Director	1 Never Married 2 Marr 3 Widowed 4 Divorced	ried	Armed Ford 1 D Yes 2 If Yes, Give Year or Da	ces? 2 □ No 1064		f Yes, speci		Specify:	Puerto	ecify Yes or No Rican, etc.)	- 1		, White,	etc.			
Medical Exp	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t's Educ st grade	ation completed) College (1-	4or 5+)		dent's Usual kind of work DO NOT use	Occupa done d retired)	tion uring most	of work!	ng		nd of Bus					
2		12	4			Sales	Clerk								Store			
matic event, It a Mi	To Be	17. Father's Name (First, Middle, Orville Mix							Arm	illia	(First, Middle, Batem:	an M	lix					
other traum		19a. Informant's Name/Relations	hip <i>(Ту</i> р		sband	19b. Mailir 176	ng Address 10 Wa	Street a.	r Roa	or Rura d	Oldto	er, City or WN	Town, S	tate, Zip MD	2155	5		
any injury or oth once.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		emoval from S	late .	Place of Dispo cemetery, cren . Olive Co	natory or oth	er place	)		2/26/2004		towr	,	wn, State	D		
any inj	-	21. Signature of Funeral Service	License	100	11	22					ome, PA :: Cumbei	rland	MD 3	1502				
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ector: After this certific by the funeral director,	ledical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Note Natural 5 Pending investig  3 Suicide 6 Could n determing determing the control of the count of t	g ation not be ned	28a. Date of (Month,  28e. Place of building	Injury Day Year)  Injury - At h., etc. (Specifiest of my knows of examina	Injury  ome, farm, stre	M et, factory, ( occurred at estigation, in	1 TY	, date and nion, death	21	City or Town	ause(s) a ate and p	and mann place, and signed (I	er as stat due to t	ted. he cause(s)			

07354 State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 13.7 Carlton Gregory Roberts 2004 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Washington Advntist Hospital Takoma Park MD Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 1 Year Days Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Min. 1**X**|XM 2□ F 46 Yrs. 229.94.9332 Dec. 14.1957 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f shoventy injury or other traumatic event, I'm Madical Examinan must be notified. Virginia Richmond 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1418 Clarkson Road Apt. B 23234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Be Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Painter</u> Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charlie D. Roberts Rosa Brockman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Pickett---Sister 2924 Gatehouse Road Norfolk, Virginia 23504 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ™Burial 2 Cremation 3 Removal from State Roosevelt Mem.Park 1.10.2004 ` 4 ☐ Donation \_ 5 ☐ Other (Specify) Chesapeake, VA. 21. Signature of Fineral Service Lensu 22. Name and Address of Facility 104 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 23a Part1 Enter Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition days Priysician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown signed by Part II. Wher significant conditions contributing to death but not requiring in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig page 2 should b 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No After this certificate ASTIC Yes 2□No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 XNo 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Nnpatient 2 T FR/Outpatient 3 DOA 27. Manper of Peath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AZ WASHINGTON AND HOSP TAKONAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EAGAN 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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9 2004

ORIGINAL

			1 = For State Registrar	State of	Marylan				ealth a Death	and M		Reg. No	-2001.		7355
â	Physicia	an	1. Decedent's Name (First, Middle, I								2. Date of Dea	Da			ne of Death
	/Medic	al		JLLIVAN	uael .	-	4h Cihr	Town or	Location o		Februa	_	17,200 County of Deat		534 "
	Examin	er	4a. Facility Name (If not institution, g  Memorial				40. City,	Eas		n Death		1	Talbo		
	Funeral			Sex, 7.	Age (In yrs. I	last birthday)	If Unde Months	r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Da	h Vear			ate or Foreign
	Director		216-16-5317 Usual Residence of Decedent	10 <b>X</b> M 2□F	84	Yrs.		Days	Hours	WIII.	Sept.6	,19	19 Mary	land	
ırylan	ahow Test	-	10a. State 10b. County		10c. City	y, Town or Lo									de City Limits Yes 2 ☐ No
he M	-88-1	Director	Maryland Talbo	ot		East		o Code				10a Ci	tizen of What Co		
with t	a or S	٥						21601				rog. Or	USA	uy	
death	ms 23	era	36 West Stree	12. Was Deced		S. 13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	.	14. Race - Ame		ın,
within 72 hours after death with the Maryland	al', or iter	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forc 1 XYes 2 If Yes, Give Year or Date	□No		if Yes, spe 1 ☐ Yes	. /	n, мехісап Specify:	i, Puerto	Mican, etc.)		Specify: b1	ack	
72 hoi	ical E	ted	15. Decedent's (Specify only highest)	Education		16a. Dece	dent's Usu	al Occupa	ation fu <i>ri</i> na most	t of worki	na	16b. K	(ind of Business/	ndustry	
ithin 7	e. Men "r	Completed	Elementary/Secondary (0·12)	College (1-4	or 5+)			ise retired	turing most				lbot Cou		
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	ntal H	Be	17. Father's Name (First, Middle, La								(First, Middle, unk	INIZIUGI	, Sumame,		
should	and Mental is marked of aumatic eve	၉	Irvin W. Sul.  19a. Informant's Name/Relationship	livan		19b. Maili	na Addres	s (Street a		ella er or Bura		er. City	or Town, State, 2	ip Code)	
1 and 2 s			Aaron Roberts 20a, Method of Disposition		20b. P	250 lace of Dispo	2. Wi	nche		Stre		.D	, Balti	nore,	
Pages	if ite		1 Bunat 2 Cremation 3	☐Removal from St	ate	emetery, cre	matory or	other plac	1				•		
	Department Important: I any injury o	1	*4 ☐ Donation 5 ☐ Other (Spe 21. Signatur → uneral Service Lice		Ca	apitol					/2004		ver, De	lawar	e
permit.	Depa Impo any ii		Dull	tu C			Benn	ie Sr	nith I	Fune	ral Hom	e Mars	yland 21	601	
DI	nysician		23a. Part I. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	omplications that cause on each	used the death ch line.	h. Do not en	er the mo	de of dyin	g, such as	cardiac c	or respiratory ar	_		Approx	kimate Il Between and Death
1	Medical kaminer		disease or condition resulting in death)	a. Due to (or	r as a consequ	My E	CINCS	1001		411/	/ 69-4			Cyl	SAN ]
petr	Insit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or	r as a consequ	uence of):									
te be executed	ysician and he burial-transit	cai Exa	resulting in death) Last	Due to (or	r as a consequ	uence of):									
eath certificate	g phy as the								-						
The law requires that the death certifica	been signed by the attending phy should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Feta nt at time of d	Ideath 3[	⊒Ectopic p ⊒ Other (s			-			23d. Date of del Month	very Day	Year
that th	ed by detac	, Ph	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	inderlying	cause giv	en in Part I.		23e. Did to	obacco	use contribute to	the cause	e of death?
uires	sign Id be	d by	lypon Ten	1100							101	res 2	2 □ No 3 🗗 🗗	obably	4 🔲 Unknown
w req	beer	Completed	1/3/		-						24a. Was		24b. Were at	topsy find	lings available
he law requires t	page 2 s	шс									autor perfo	rmed2			of cause of
	certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	Check only o		1 10100	245 140	
Physician:	rthis certifica	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆 Inj	patient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4 1000	irsing Ho	me 5 Resid	dence	6 ☐Other (Spec	cify)	
Attending Ph	After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month)	Injury , <i>Day</i> Ye <i>ar</i> )	28b. Time o Injury	of M	28c. Injun Wor 1 🖂	/at k? Yes 2□		28d. Describe I	now inju	ury occurred		
ō	s after death. Il Director: A Id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place 0	of Injury - At ho g, etc. (Specif	ome, farm, st	reet, facto	ry, office			28f. Location (S City or Tov		nd Number or Au e)	ral Route	Number,
e Hospital	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical (		Physicien: To the base keminer: On the base and manner	is of examina										use(s)
Toth	withii To th comp	ž	29b. Signature and title of certifier	7/1/	1		29	c. Licens				29d. Da	ate signed (Monta	h, Day, Ye	oar)
			16/1/2	Chitin	> m	$\mathcal{V}$		D.	3146	66		7	117/09	/	
			30. Name and address of person w	ho completed cause	of death (Iten						1				
	Versel.		Dr. Ludwig E	glseder,I	II		ynwo	od Dr	., Ea	ston	,Maryla	ınd	21601		
	Sta		31. Date filed (Month, Day, Year)	4 2004 32. Re	strar's Signa	ature	Soral	60							

Louis Sullivan

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 2014 07356 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Rochelle Lynn Sandy February 25, 2004 4:00 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 39 Devonshire Road Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 213 F 31 Director 216-88-2021 March 4, 1972 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If them 27 la marked other than "natural", or items 23a or 23a-f show any Injury or other traumstic event. It a Mardian Exercise. 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits r is marked other than "natural", or items 23s or 28e-f show traumatic event, the Medical Examiner must be notified at 1⊠ Yes 2□No Funeral Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 39 Devonshire Road 21740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Merital Status 1 ☐ Yes 2 ☒ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify Completed by 3 ☐ Widowed 4 ☑ Divorced White Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Land Surveying Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Mehrl Stull, Jr. Martha Brashears 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pandora Stotler / Sister 37 Devonshire Rd. Hegerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Feb. 26, 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Resthaven Crematory Frederick, Maryland 22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licensee 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part / Enter the disease, or corrollications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physicien end for use es the buriel-trensit or Attending Physician: The law requires thet the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of deeth? 2 DH6 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after deeth.

To the Funeral Director: After this certified completely filled in by the funerel director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 → Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Naturel
2 Accident 5 Pending 1 Yes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

70505

32. Registrer's Signature

2004

State of Maryland / Department of Health and Mental Hygiene 2 1 1 07357 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 23, 2004 8:00 P.M Shrader Ann Betty /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Glade Valley Nursing & Rehab Center Walkersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF June 24,1932 Director Connecticut 047-24-6479 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral', or Itame 23e or 28a-f ehow Examiner must be notified at 1★ Yes 2 No Walkersville Maryland Frederick Director the 10g. Cilizen of What Country? 10f, Zip Code 10e. Street and Number with 21793 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itame 23e any highry or other treumatic event, the Mudical Examiner count. Once. 317 Silver Crest Drive by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Linda Cottreau Joseph W. Deveau ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 317 Silver Crest Dr. Walkersville, MD 21793 Joseph Shrader/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/28/2004 Frederick, MD 21702 Resthaven Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructure Pulmonery Diserse Physician 5 year /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Discare 24a. Was an page 2 : autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FUBRULTY 25, 2004 D41619 Levrer mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 63 Thomas Johnson Dr, Frederick, MD Dr. Michael Lerner 32. Registrar's Signature 31. Date tiled (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 25

			1_ For	State of Mar	yland	d / Depa	artment of I	Health and N	lental Hyg	iene	On L	07358
			Registrar  1. Decedent's Name (First, Middle, Last)			Cei	tificate of	Death	2. Date of Dea	eg. No.	. 0 0 .7	3. Time of Death
	Physici			Clay H.	Sti	ne			Month Feb.		2ďď4	3:30 PM
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town,	or Location of Death			ounty of Death	
		Ξ.	5018 Whisperin	g Pines	Lan	е		rederick			Freder	rick
П	Funeral Director		213-24-9736	7. Age (	(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) Dec. 7	Year) 19	9. Birthp <i>Cour</i> 27 MI	place (State or Foreign htry)
	and wc		Usual Residence of Decedent  10a. State 10b. County	1	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	ter death with the Maryland Itams 23a or 28a-f show Instituted by Instilled ut	tor	MD Fred	erick		Frede	rick					1 ☐ Yes 24 ☐ No
	or 288	Funeral Director	10e. Street and Number				10f. Zip Code		1	0g. Citize	n of What Cour	ntry?
	s 23a	ral	5018 Whispering				21				SA	1.26.
		nne.	11. Marital Status  1 Never Married 35 Married	12. Was Decedent Ev Armed Forces? 1 □ Ves 2 □ No		5. 13.	Mas Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	14	. Race - Americ Black, White,	
ن وي	hours after tural', or ita	ρ	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			1□Yes 2½ No	Specify:		S	ресіfy: Whi	te
ဂ င	22 22 33	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece (Give	ient's Usual Occu kind of work done	pation during most of work od)	ring	16b. Kind	of Business/In	dustry
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2	filed Hygie othar ant, II		17. Father's Name (First, Middle, Last)				Luck di	18. Mother's Nam	e (First, Middle, I			
<u> a</u>	Aental Aental rkad tic ev	To Be	Charles W. S	tine				Ru	th Hefi	fner		
lary	2 sho and N is me	i i	19a. Informant's Name/Relationship (Typ			19b. Mailir	g Address (Stree	and Number or Rur	al Route Number	City or 1	own, State, Zip	Code) 21702
e, S	s 1 and if Health item 27 othar ti		Kathleen Stine  20a. Method of Disposition	(wite)	20h Pt			ering Pi			ederic	
_	8 = 5		1 🔀 Buriai 2 ☐ Cremation 3 ☐ Ri '4 ☐ Conation 5 ☐ Other (Specific	emoval from State			sition (Name of natory or other pla	cery2/20				
Saltimo	permit. Pa Departmen Important: any njury once.		21. Signature of Fundal Service Licen	100	Re							
ă	Dep any		Muyo	MOUR		3	1 E. Ma	S. Thomp in St.,	son Fur Middle	era	л, Home n, MD	21769
			23a Part1. Enter the disease, or complications, or heart failure. List only on	eations that caused the cause on each line	ne death	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Murocan	rdio		farat	ΙοΛ				Onser and Death
	/Medical Examiner		Tosuming an assum,	Due to (or as a	- 60		2010	Les Di				Service Conse
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequ	ence of):	My Car	tery Di	sease.		-	arter of year
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Huper	tens	Sior	1				5	ieveral year
, 00,	te be executed ysician and te burial-transit		resulting in death) Last	Due to for as a	consequ	ence of):						J
200	± × ±	dlcal	_ d									
XOR	n certif anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of			T			230	d. Date of delive	ery
р Э	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 2 4∐Pregnant at tir 9∏Unknown			Ectopic pregnand Other (s <i>pecify</i> ) _				Month	Day Year
7.	s that I	<b>by</b> Рh	Part II. Other significant conditions con	tributing to death but	not resu	Iting in the u	nderlying cause gi	ven in Part I.	23e. Did tot	acco use	contribute to th	ne cause of death?
	w require been sig should b	ed b	Tobacco Abuse						1 □ Y€	s 2 🗆 I	No 3 ☐ Prob	ably 4 □Unknown
vital Records,	law re nas be	Completed						·	24a. Was a autops	V	prior to cor	psy findings available mpletion of cause of
E E	siclan: The law certificate has b irector, page 2 s								perform 1 Yes 2		death?	2 🔀 No
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 🗆	ER/Outpatier	t 3 DOA Ott	26. Place of Deat	h <i>(Ch</i> eck only on me 5 <b>⊠</b> Reside		70th as (0if	
ō	Phy ald	n; To	27. Manner of Death	28a. Date of Injury (Month, Day )		28b. Time of Injury	1 3 DOX	ry at	28d. Describe ho			//
201	andin sath. or: Aft he fun	atlo	1 Natural 5 Pending investigation	(Monar, Day 1	(Gas)	mjury		Yes 2 □No				
UNISION	or Att after de Diract in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At hor (Specify,	me, farm, str )	eet, factory, office		28f. Location (St. City or Town	reet and f n, State)	Number or Rura	I Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of eer: On the basis of e	my knov xaminati	vledge, death ion and/or in	occurred at the tivestigation, in my	me, date and place, opinion, death occur	and due to the cared at the time, da	use(s) ar ate and pl	nd manner as st ace, and due to	ated. the cause(s)
	To tha within 2 To tha comple	Mec	29b. Signature and title of certifier	and manner state	•			se number			signed (Month,	
	->-0		> Suriser 19	willes &	10		1400	56961		02-	18-0	4
	3		30. Name and address of person who co	mpleted cause of dea	th (Item	23а) (Туре,	Print)	0	h 2 h			2 . 1
			Louise K. Butler, 31. Date filed (Month, Day, Year)	DO 1110 32. Registrar	Signa	idical	Campu:	56961 SRd. St.	107 Ha	gerst	own, M	1) 21742
	Sta Registr		FEB 2 6		Miller	j.	Sports					

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2004 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** Month Dev Year John C. Seymour /Medical 02 22 04 0001 A.M 4a. Facility Name (If not institution, give street end number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Hospital Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year Birthplace (State or Foreign Country) Days Months Director 214-42-0310 Yrs 60 11-06-43 Usual Residence of Decedent WV 10a State 10b. County Show 10c. City, Town or Location 7 is marked other than "neturs!", or items 23s or 28s-f shor traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits WV Mineral Ridgelev Directo 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 3 Spinnaker Ct. 26753 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes: 11. Maritel Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married Maryland 21215-0020 2 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Goodyear Manager Tire & Rubber Co. 17. Father's Name (First, Middle, Last) æ 18. Mother's Name (First, Middle, Maiden Surneme) John C. Seymour ဥ Phyllis Moran 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Scott Seymour Baltimore, 2319 Hillside St. Cuyahoga Falls, OH.44221 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Philos Cemetery 2-25-04 Westernport, MD. 22. Name and Address of Fecility Fredlock Funeral Home 21. Signature of Funeral Service Licen Jones St. Piedmont, WV. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Cardiomyopathy Examiner unknown Due to (or es a consequence of): or Attending Physicisn: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, ed by the ettending physician detached for use as the buna Physician/Medicai Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed? certificate has b lirector, page 2 sl 2/2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( (Specify) \) ဥ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) d54756 2 - 22 - 04eted cause of death (Item 23a) (Type, Print) Robert Rapp 912 Seton Drive, Cumberland, MD. 21502 31. Date filed (Month, Day, Year) 32. Registrer's Signature State FEB 2004 Registrar 4 B Goods

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygien 200107360 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician**  $A^{M}$ 2004 0830 Miriam Florence Scott March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Cecil 1205 Leeds Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🂢 F 89 Yrs. July Director Maryland 218-40-0781 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show r than "netural", or items 23e or 28e-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Cecil Elkton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 1205 Leeds Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify φ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: If item 27 is marked other It any injury or other traumatic event, It. 2006. Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eli Clark Farwell Meta Viola Spratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol S. Mackie/Daughter 1203 Leeds Road Elkton, Maryland 21921 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
St. John's March 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lewisville, \* 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 2004 Fennsylvania 21. Signatu v of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician AUZIC CRITTON /Medical Due to (or as a consequence of): Examiner Serre YCKUCUR SYSTOUR DEFENITION Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 1 Yes 2 🗆 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Certification: To 22 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. May fer of Death 28a. Date of Injury (Month, Day Year) ieral Director: After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a

To the Funeral i

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 3/3/0address of person who completed cause of death (Item 23a) (Type, Print) 2600 Glasgow Avenue, Suite 108, Newark, Delaware 19702 <u>Erik S. Ma</u>rshall M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		•	1 - For State Registrar	St	ate of M	larylan				ealth a	and M		Reg. No	04	07361	
	Physici	an	Decedent's Name (First, Middentification)									2. Date of De Month	Day	Year	3. Time of Death	
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	F		5 Social Security Number	6. Sex			last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign	_
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	d within 72 hours after death with the Maryland piene. r then "naturel", or Itema 23s or 28s-f show the Modical Examiner trust be notified at	Funeral	11. Marital Status	12. W	/as Deceden	t Ever in U	.S. 13.	Was Dece	dent of H	ispanic Ori	gin? (Sp	ecify Yes or No	- 14. R	lace - Ameri		-
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93	rali, o	i by	3 ☐ Widowed 4 🏋 Divorce	4 Å	Yes, Give ear or Dates:			1 🗆 Yes	2 <u>M</u> No	Specify:			Spec	city: WI	HITE	
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Maryland	E B E E	-	19a. Informant's Name/Relation	ship (Type, P	rint)		19b. Maili	ng Address	(Street	and Numbe	r or Rur	al Route Numb	er, City or Tov	vn, State, Zij	o Code)	_
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ore,	es 1 an of Heal fitem 2 r othar		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Demo	al from State		Place of Disponentery, crea	sition (Name	me of other plac	e)	ľ	Date	20c. Locatio	n - City or T	own, State	
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s, P.O. Box 68	es that the death certificate igned by the attending phy. be detached for use as the	d by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significent condit	1 4 9	yes, outcom Live birth Pregnant Unknown	2 ☐ Feta at time of d	ll death 3 [ leath 5 [	Ectopic p	oecrty)			23e. Did t	obacco use co		rery Day Year the cause of death? bably 4 □Unknown	
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Division	l or Attand after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined 28	Be. Place of In building,	njury - At h	ome, farm, st	eet, factor	y, office			28f. Location ( City or To		mber or Run	al Route Number,	
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	Regist	ar	L F R	z. 4 7111	4	comme -	138	ZAN BAR	20							

State of Maryland / Department of Health and Mental Hygiene 200 l 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 4:55 PM **Physician** FEBLUARY 23, 2004 FREDERICK LUCIAN WOODS, JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JAN 17 192 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Country)
TEXAS 1**X** M 2□ F 83 Yrs. Director 458-18-4370 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow the Medical Exercitor houst be notified at Yes 2 No Director EASTON TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 HISA 313 LINDEN AVE. 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: hours after 1 □ Never Married X Married ō Specify: WHITE Maryland 21215-0036 1 Yes 2X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) marked other than Elementary/Secondary (0-12) 4 MANUFACTURING 12 MECHANICAL ENGINEER nd 2 should be filed.

Ith and Mental Hygis

27 Is marked other
r traumatic avent, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NELLIE TEMPLE FREDERICK L. WOODS, SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 313 LINDEN AVE., EASTON, MD 21601 DIANE G. WOODS/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 2-27-2004 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee once. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 21. ( STRUWSH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ELECTRICAL MECHANICAL DISSOCIATION 30 MINUTES /Medical Due to (or as a consequence of): Examiner ARTERY CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ASCENDING ADRTIC ANEURYSM attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2/ No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? 2/2 No 1 Yes 2 No Hospitel or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manufer of Death Medical Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours aft • Funeral Di letely filled in 🕼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

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completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CONERING H0058349 FEBRUARY 23,200 PHUSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. UNIVERSITY PARKWAY BALTIMORE, MD 21218 EDMUND A. TORI D.O. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

		•	1 - For State Registrer	State of Ma		/ Depa		t of H	ealth a		ental Hyg	jiene	200	Lj	07364	
			1. Decedent's Name (First, Middle, Last)							1	2. Date of Dea Month	_			3. Time of Death	_
	Physici: Medic/			James	A. Yo	ung	Sr.				Februai	-			8:00a M	
	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City,	Town, or	Location of	f Death		4c.	County of De	ath		
75			9000 Gue Road		// - · · · · · · · · · · · · · · · · · ·	. A 5 1 a5 . 6 . 1			scus	14 Hrs. L			Mont			_
	uneral irector		5. Social Security Number 6. Sex 140–12–3829	M 2□F 7. Age	(In yrs. la:	st birtnoay) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day	Year)	9. 8	Count	ace (State or Foreign y)	
	ii ectoi		Usual Residence of Decedent		79					E	lugust	4,13	924   (	Ohi	0	_
rylan	how		10a. State 10b. County		10c. City,	Town or Lo	ocation							10	d. Inside City Limits	
e Ma	li e	cto	Maryland Montgo	mery	Dama	scus									1 ☐ Yes 2 ☑ No	
vith th	De no	Director	10e. Street and Number				10f. Zip				1	0g. Citi	zen of What	Count	ry?	
aath v	s 23s	eral	9000 Gue Road	12. Was Decedent E	uor in II C	12	Was Daged	208		in? (Case	ity Vac ar Na		ited S			_
fter d	riter	Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married	Armed Forces?		. 13.	If Yes, spec	ify Cubar	n, Mexican,	Puerto R	ify Yes or No- ican, etc.)		Black, Wi			
036 urs a	e, je	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII		1□Yes 2	ON K	Specify:				Specify:	Wh	ite	
21215-0036 d within 72 hours after death with the Maryland	Date:	Completed	15. Decedent's Educ (Specify only highest grade			16a. Dece	dent's Usua kind of wor	Occupa k done d	ition Jurina most	of working	2	16b. Ki	nd of Busines	s/indu	ıstry	
A figure	ne W	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT us	e retired)								
N pô	nt, th	ပ္ပ	17. Father's Name (First, Middle, Last)	22		]	Law Er	1			First, Middle,		tgomer	у (	County	_
and be	o per	o Be	William Young								llips	viai30//	ourname)			
Maryland d 2 should be file	is marked other than "natural", or items 23s or 28s-f show sumatic event, the Midical Examiner must be notified at	2	19a. Informant's Name/Relationship (Typ	pe, Print)		19b. Maili	ng Address	(Street a			Route Number	, City o	r Town, State	Zip (	Code)	-
	27 T.		James A. Young Jr.	/Son		6197	Landi	ng I	rive,	Eld.	ersbur	, M	arvlan	d 2	21784	
or se	- b-		20a. Method of Disposition	amazzat from State	20b. Pla	ce of Dispo	osition (Nam matory or ot	e of		Da			cation - City			
Baltimor permit. Peges Department of	ent: If ury or		1  ☐ Burial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Dama	scus	Cemet	ery	2/	26/2	004 I	ama	scus,	Mar	yland	
Salt ermit.	Importent: I any injury o once.		21. Signature of Juneral Service License	90	/	022	2. Name and	Address	s of Facility	rth P	. A., 1					
u ac	트롤리	1	Jan Dr	Mus	/	26	6401 R	Ridge	Roac	l, Da	mascus	. Ma	ryland	20		
	sician edical		23a. Pert1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	o.	r D					ASS				Approximate nterval Between Onset and Death	
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		ler	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):								-		-
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760, te be executed	sician and burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):								1		
9	2 0	dical		l										-		_
Records, P.O. Box 68 The law requires that the death certifica	attending phy I for use as the	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of	of oregnan	~v								CI.		-
Bath (	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal d	leath 3[	□Ectopic pre					2	23d. Date of d Month		/ Day Year	
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s that	been signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death bu	t not result	ing in the u	nderlying ca	use give	n in Part I.		23e. Did tol	oacco u	se contribute	to the	cause of death?	
odnie odnie	en sig	edt	Hypertension,	Decelore	45 Y	Ne )	ملال	5			1 □ Y	es 2[	□No 3 💢	robal	oly 4 □Unknown	
Records,	S CI	Completed	\)								24a. Was a autops		24b. Were	autops	sy findings available pletion of cause of	
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Vital	is certificete director, pac	Be	25. Was case referred to medical examiner?							of Death (	Check only on	e)				
Physi	this al di	. To	1 Yes 2 No	lospital: 1  Inpatier 28a. Date of Injury		R/Outpatier		-	4 🗀 Nurs		Reside			ecify)		_
e gig	After	tlon	1 Natural 5 ☐ Pending	(Month, Day	Year) 2	8b. Time of Injury	M	Bc. injury Work	ati ? ′es 2.⊟N		d. Describe ho	w injury	/ occurred			
Division of Vital or Attending Physician:	octor: by the	Certification:	3 Suicide 6 Could not be	28e. Place of Inju		ιθ, farm, str	reet, factory,			-				Rural I	Poute Number,	-
al or safte	I Dire	Serti	4 Homicide	building, etc.	. (Specify)						City or Town	, State)				
Di To the Hospital or within 24 hours afte	To the Funerel Director: A completely filled in by the fi	Medical (	29a. Certifier (Check only one) TECertifying Phys	sician: To the best o ner: On the basis of and manner stat	examinatio	edge, deatl in and/or in	h occurred a vestigation.	it the time	e, date and inion, death	place, an	d due to the ca at the time, d	ause(s) ate and	and manner : place, and di	as stat ue to t	ed. he cause(s)	
To th	To tr comp	Ň	29b. Signa and title of certifier	00	(313.10)		29c.	License	number	251041	2	9d. Date	signed (Moi	nth, Da	ay, Year)	
			John Lui	hh	W	,		D.	227	29-	MD	Fε	bruar	<i>y</i> 2	3, 2004	
10+			30. Name and address of person more	1												
	L STATE OF		John Kijak Jr. MD	9815 Ma			Dama	scus	, Mar	yland	1 20872					
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registra			don	alle)								

State of Maryland / Department of Health and Mental Hygien 2001 07365 State RegistremEND ITEM #27 PER ME G829 3/10/04 Jertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** FEBRUARY 9:12 A N. HERBERT ZIGER 14. 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F 578-28-7649 Director WASHINGTON, 76 0/8/1927 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County •how 10d. Inside City Limits s 23a or 28e-f shov 1 ☐ Yes 2 No MARYLAND MONTGOMERY KENSINGTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9714 HILL STREET 20895 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 21♥ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ WHITE 3 Widowed 4 Divorced netural Completed 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry within 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be intent of Health and Mental Intent: If item 27 is marked or ဂ္ဂ EDWARD ZIGER ROSE GOLDBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is OUILLIE ZIGER/WIFE 9714 HILL ST., KENSINGTON, MD 20895 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H important: If itser eny injury or oth once. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT. LEBANON CEMETERY 102/16/2004 permit. Departn 21. Signature of Funeral Service L 22 Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOPULMONARY ARREST disease or condition 3 MINUTES /Medical resulting in death) Due to (or as a consequence of): Examiner SUBDURAL HEMATOMA ~~ 19 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CALEXAMINER Examiner attending physicien and for use as the burial-transit THOU NE POVED BY ME Due to (or as a consequence of) .O. Box 68760, Physician/Medical CERTH IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, THROMBOCYTOPENIA; Pelvic fracture 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No MYELODYSPLASTIC SYNDROME 24a. Was an page 2 autopsy Hypertensive atherosclerotic cardiovascular disease certificate 1 Yes Division of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dther: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No in by the funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After T WiNatural 5 Pending investigation Jan 27, '04 Unknown death. 1 Yes 27 No XX Accident Subject fell Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 9714 Hill St, Kensington, MD outside within 24 hours a

To the Funeral C

completely filled filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) ru 54327 MD FEBRUARY 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4927 DONALD WRIGHT, AUBURN AVENUE, 2ND FLOOR, BETHESDA, MD 20814 M.D. 32. Segistrar's Signature State Registrar

HERBER

ZIGER,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 2004 March 5, Dorothy Florence Alfano 0655 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
March 2, 1924 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Days Months Hours Min. 1 M 20 F 80 Canada Vre 261-66-3969 Director Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at t√TYes 2 No Director Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9701 Fields Road, Apt. 706 20878 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Permit. Pages 1 end 2 should be filled within 72 hours after Department of Heelth end Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes **②** No Specify: white Completed by If Yes, Give Year or Datas: Specify 3□XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) roperty Receptionist Management 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Tabb Florence Mariner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19311 Dunbridge Way, Montgomery Village, MD 20886 Carolyn K. McKenzie, Caregiver other: 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremation 3 ☐ Removal from State injury or 5 ☐ Other (Specify) Baltimore Crematory at LP 3/9/04 Baltimore, MD 4 Donation 21. Signature of Funeral Service Licensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 26a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Congestive Heart Failure months Examiner Aortic Stenosis years by Physician/Medical Examiner The law requires that the death cartificate be executed as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiclen and Rheumatoid Arthritis Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Renal Insufficiency ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? t Ves 2 No 1 Yes 2 No within 24 hours aftar death.

To the Funeral Director; Aftar this certifica completaly filled in by the funeral director, I or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: Hospice 1 ☐ Yes ZXNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Home 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1XXNaturel 2 ☐ Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier end manner stated ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 2 D09470 March 5, 2004 MO 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Dr. Eugene P. Libre

MAR 1 1 2004

31. Date filed (Month, Day, Year)

32. Registrer's Signeture

10400 Connecticut Avenue, Kensington, MD

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** Bell Ashwe 204 9230 PM awrence /Medical 4b. City, Town, or Location of Death Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Altimore SALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, You Jan. 21 1 If Under 1 Year 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 □ F 1925 Director 230-12-6295 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Dunda1k Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1706 Searles Road 21222 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2X Married Specify: White 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) NA 8 Iron Worker Iron Workers Local 16 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Bel1 Ashwell Eu11a Fannie Chiso1m ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Thelma Ashwell ( Wife ) 1706 Searles Road Baltimore. Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date March 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayview Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 12,2004 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. Dabrowski-Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 etions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a. Part1 Enter the disease, or compli shock, or heart failure. List only of Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final diseese or condition resulting in death) Bacteremia Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes RLUNO completaly filled in by tha funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 1□ Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation t ☑Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that tha death certificeta be executed Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0020

State Registrar

105410 31. Dete filed (Month, Day, Year) MAR 1 1 2004

29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier (Check only one)

> MO 32. Registrer's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Yeer)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Month **Physician** Allendor 6:30A.N larch 2004 6 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner saltimore ella leris imonic If Under 24 Hrs. Sm If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours 1**X**M 2□ F 399-34-8691 Usuel Residence of Decedent Yrs. Director May 2,1931 10c. City, Town or Location 10a Stete 10b County 10d. Inside City Limits 28a-f show Baltimore 1X7Yes 2 □ No Timonium Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 154 items 23a 205 21093 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? TYes 2 □ No Army If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 2 should be filed within 72 hours efter on and Mentel Hygiene.
Is marked other than "natural", or fter 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer 19 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) AllendorF MD 31093 20b. Place of Disposition (Name of cometery, crematory or other place) limonium avenne Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ 3-15-04 Metro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature al Service Lieure 1939 and ener 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bean failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE Examiner Due to (or as a consequence of): Examine buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): ettending physician for use es the burie of Vital Records, P.O. Box 68760 by Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has been s irector, page 2 should Completed 24a. Was an autopsy performed? 1□Yes 2XNo 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ၉ 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3D DOA 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNaturel 2 ☐ Accident 1 ☐ Yes 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 157 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
MAR 1 1 2004 3. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

BRUCE ALLENDORF

		1 - For State Registrar	State of Marylan	id / Depa <i>Cei</i>	artment of rtificate of	Health : Death	and Mental I	Hygien Reg. N	e2004	07369
Physic	ian	Decedent's Name (First, Middle, Last					2, Date o Month	D	ay Year	3. Time of Death
/Medi	cal	Marguerite E. Br			4b. City, Town,	or Location	Marc		c. County of Deeth	
Exami	ner	Paradise Assisted			Catons				_	timore
Funeral		Social Security Number     6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Yea Months Days	r If Under		Birth Day, Yea	9. Birth	place (State or Foreign intry)
Director		214 05 5750	DM 2∏F 90	Yrs.	Working Days	Hours	Oct :			yland
and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
Maryll f eho	ō	Maryland Anne Aru	ındel Pa	sadena						1 ☐ Yes 2 ☐ No
ith the Marylar or 28a-f ehow	Director	10e. Street and Number	ilde1 1 d	Dade: Id	10f. Zip Code			10g. C	itizen of What Cou	intry?
23a o		524 Sylview Driv	<i>r</i> e		2112	22			United	States
filed within 72 hours after death with the Maryland Hygiene. Whysiene. Wher then "natural", or items 23a or 28a-1 ehow ant, tra Medical Exerting must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of	Hispanic Or ban, Mexica	igin? (Specify Yes on, Puerto Rican, etc.	No-	14. Race - Amer Black, White	
or its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🜠 No If Yes, Give	+	1 ☐ Yes 2√2 No				10.1	hite
72 hours after dea "natural", or Items idical Examinar m		3 ▼ Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occu	ination		16h	Kind of Business/li	
n na 72	Completed	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retir	e during mos	st of working	100.	Kind of Dusinessyn	idustry
d with piene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Reception	nist		Sta	ate Gover	nment
other vent,	BeC	17. Father's Name (First, Middle, Last)	1				er's Name (First, Mic			
should be nd Mental marked c	70	John Thomas Fren	nch				Grace Mae	Nels	son	
		19a. Informant's Name/Relationship (T)					er or Rural Route Nu			,
and lealth m 27	1 8	Barbara A. Shiflet			ylview I	rive,	Pasadena Date			
Pages 1 nent of H int: if ite		20a. Method of Disposition 1    ↑ The property of the propert	Removal from State	semetery, crer	matory`or other pl				Location - City or T	
t. Pa ntmen rtant: njury		<ul> <li>4 ☐ Ponation 5 ☐ Other (Specify)</li> <li>21. Signature of Fureral Service Licens</li> </ul>			n Garden		3/9/2004		ciottsvil	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Furneral Service Cicens	2 2 5		407 TT: 14	ess of Facili	<sup>ty</sup> Hubbard	Fune	ral Home,	Inc.
	-	23a. Part1. Enter the disease, or comp	lications that caused the deat				venue, Bal		ce, Maryl	Approximate
Discontinue		shock, or heart failure. List only o Immediate Cause (Final								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. DEHY DRAT  Due to (or as a conseq							month
Examiner		Constitution for the state of t	DEMENT							woods
D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se s consaq	uenca of):						years
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq		KE					Y
cate be executed obysician and the burial-transit					710 05					
physicate sthe	dical		d ARTERIUS	CLERE	LIC CIZ	ما کرنے اسل	LAL VASCU	- 6	E4-9E	-
The law requires that the death certificate has been signed by the attending propage 2 should be detached for use as it	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of deliv	verv.
leath atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnand Other (specify)	су		_	Month	Day Year
oy the	hysl	9 Unknown	9□ Unknown							
uires that the designed by the a	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause g	iven in Part I	l. 23e. [	oid tobacco	use contribute to	the cause of death?
v require been sig should b							1	☐ Yes 2	2 ☑No 3 ☐ Pro	bably 4 □Unknown
law re as be 2 sho	Completed							Vas an utopsy	24b. Were aut	opsy findings available ompletion of cause of
The The ate h	Com						! p	erformed? s 2 N	death?	
sician; The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Jameitale				e of Death (Check or	nly one)	ASISTER	HUINE
Physi this o	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier	IL JUDON		ursing Home 5 12 F		6 Other (Speci	fy)
Attending Physician: or death. ector: After this certification of the funeral director.	lon	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	W	ork? ⊡Yes 2		be now inj	ury occurred	
death death ctor: y the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, str				on (Street a	and Number or Rur	al Route Number,
d in b	Certification:	4 Homicide	building, etc. (Specif	y)	,,		City or	Town, Star	te)	
To the Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, deat	h occurred at the	time, date ar	nd place, and due to	the cause(	s) and manner as	stated.
n 24 he Fu	edical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, dea	ath occurred at the til	ne, date ar	nd place, and due t	to the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier	(10000000	A A Section		nse number	-/		ate signed (Month,	-
0		Haurence	- Accept	7 ~0	00	178	6	MAI	RCH 08	,2004
O.		30. Name and address of person who c	GALLAGIE	n 23a) (Type.	()					
	040	31. Date filed (Month, Day, Year)	32. Registrar's Signa	LANCE	199	10.05	VICLEIM	ARY	AND 2	1728
S	ate	0000 1	2001	A	14710					

			For	State of Maryland			ental Hygier	e 2004	07370
			State     Registrar  1. Decedent's Name (First, Middle, La.	st)	Certificate of		Reg. N 2. Date of Death	10.	3. Time of Death
	Physicia /Medic	_	William	Brightful			Wareh !	y Yeer 2004	7-10 AM
)	Examin		4a. Fecility Name (If not institution, give	1 Uphah	4b. City, Town, o	or Location of Death	4	c. County of Death	1 n
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last	birthday) If Under 1 Year		8. Date of Birth (Month, Day, Yea	9. Birthr	lace (State or Foreign
	Director		X10-10-00X0	MM 2□F 90	Yrs. Months Days	Hours Min.	JULY 28,		VSLYVANIA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location			1	0d. Inside City Limits
	e Many	ctor	MARYLAND 1	1/A	BA	TIMOR	ECIT	4	1. Yes 2 No
	with the	Dire	10e. Street and Number	TITURDAI	10f. Zip Code	2122	109/0	Citizen of What Cour	ntry?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Specian, Mexican, Puerto F	offy Yes or No-	14. Race - Americ Black, White,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Macheal Examinational be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No		, ,	Specify:	1 001
5-0036	72 hou	ted l	15. Decedent's E- (Specify only highest gra	ducation 1	6a. Decedent's Usual Occup (Give kind of work done	pation during most of workin	16b.	Kind of Business/In	dustry
21	within and the state of the sta	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Vite. DO NOT use retire	(d)	40-1/10 V	BAITIMA	RECITI
ld 21	filed with Hygiene other that	Be Co	17. Father's Name (First, Middle, Last,		17TINI CNA		(First, Middle, Maid	en Sumame)	011
ylan	should be ind Mental is marked of umatic eve	To B	CLARENCE	13	RIGHTFUL	NOR	A	CRA	+/G
Mary	id 2 shouth and ith and trauma		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (Street	and Number or Hural	Houte Number, City	or lown, State, 210	4p.21229
ore,	permit. Peges 1 and 2 Department of Health Important: If item 27 any injury or other tri once.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	come	e of Disposition (Name of etery, crematory or other pla		ate 20c.	Location - City of To	
Baltimore	Per Tanger Per Per Per Per Per Per Per Per Per P		'4 Donation 5 ☐ Other (Specif	V) ARX	BUTUS CEME	TERY 03-1	5-04 8	ALTIHORE	-, M.D.
Bal	permit. Departr Importa		21. Signature of Funeral Service Licer	M ~	22 Name and Addre	SS OF ACHITY B	NAVE	BALTO.	KAL HOME MD 21217
			23a. Pert1. Enfer the disease, or com shock, of heart failure. List only	plications that caused the death. I one cause on each line.	Do not enter the mode of dyin	ng, such as cardiac or	respiratory arrest,	0/10.0	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· Alheroseler	the Cordi	10 Vascula	dise	≈5°C	Onset and Death
t	Examiner			Due to (or as a consequent	ice of):				
	p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of):	1	line	2355	
	arecute and at-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	5/1100/102 ce of):	ATTIONS	aise	77	
3760	wrequires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	cal		d					
89 x	The law requires that the death certifica ate has been signed by the attending phr page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy	,			23d. Date of delive	anv
. Box	death of attented for u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3 Ectopic pregnanc	Ey .		Month Month	Day Year
P.0	d by th	Phys	9 Unknown  Part II. Other significant conditions	9□ Unknown	ng in the underlying cause on	ven in Part I	23e. Did tobacc	o use contribute lo ti	ne cause of death?
ds,	ures the signer	d by	Dem	entia	ig in the disconying educe gr				ably 4 Unknown
Records,	law req as beer 2 shou	piete	2				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Com					performed: 1 ☐ Yes 2 ☑	death?	2 No
Vital	Physicien: this certificant	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA Oth	26. Place of Death		6 ☐Other (Specif	v)
n of	ng Physiter this	D: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending		b. Time of linjury Wo		8d. Describe how in		,,
Division of	Attending r death.	icatic	2 Accident investigation 3 Suicide 6 Could not be	90 Place of lower - At home		]Yes 2 □No	8f Location (Street	and Number or Rura	il Route Number.
Div	after a Direct I Dire	Certification:	4 Homicide determined	building, etc. (Specify)	s, rame, street, ractory, onless		City or Town, Sta	ate)	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this compietely filled in by the funeral di	Medical (	(Check only 2 Medical Exa	nysician: To the best of my knowle miner: On the basis of examination					
	o the	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number		Date signed (Month,	Day, Year)
	()		Amatun M	Moeom N	DI	5503	[M)	greh 10	2004
	4		30. Name and address of person who	completed cause of death (Item 23	DG/Dhin	st. B.	altimor	~ MD	ANA
	Sta	ate	31. Date filed Mar D. Div, Tear)	32. Registrar's Signature	1.1.			,	
	Regist	rar		ALONE ICA SA	Brook D				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Jarrell Blake Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 1704Amend Item#6 State of Maryland / Department of Health a State of Maryland / Department / Depart , Department of Health and Mental Hygiene AKG Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day March 2004 9:26 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days | Hours | Min. | (Month, Day, Sinai Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** (State or Foreign 126-78-1366 XX M 2 Months Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? ŏ or items 23e death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important: If liam 27 Is marked other than "natural", or flee any injury or other trainment. Black, White, etc. Never Married 2 ☐ Married 1 Tes 2 No Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Coudge (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum Be 19b. Mailing Address (Street and Number or Rural, oute Number, City or Town, State, Zip Code) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asthma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Fig. 1) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and Due to (or as a consequence of) use as the burial-P.O. Box 68760 physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Scheme 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 2 □ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1☑ Yes 2 □ No 1 Inpatient 25 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. М 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature as 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 8, 2004 30. Name and address of person who complet a cau e of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2004 Registrar

nuois:		Registrar  1. Decedent's Name (First, Middle, Last,	)			of Death	2. Date of E Month		o. 2004 ay Year	3. Time of Death
nysici Medic		Elinor	Louise Brea	ads			March	9,	2004	2:10 p
xamir	er	4a. Facility Name (If not institution, give				own, or Location of E	Death	40	c. County of Deeth	
		Pine Hill Assiste  5. Social Security Number 6. Se		. last birthday,	Laur		Hrs. 8. Date of B	Birth	Howard 9. Birth	place (State or For
neral ector		579-34-9853	M 2∏F 73	Yrs.	Months	Days Hours	Min. (Month, L	Day, Year		place (State or Formintry)
10	1	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocalion					10d. Inside City Lin
a de	ţō	MD Howard	Li	aurel						1 ☐ Yes 2 ☐ X
T T	rec	10e. Street and Number			10f. Zip C	Code		10g. C	itizen of What Cou	
긜	aiD	8455 Murphy Road			207	23		U.	S.A.	
E	by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede If Yes, specif	nt of Hispanic Origin y Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	٧٥-	14. Race - Ameri Black, White	
i di	Jy F	1 ☐ Never Married 2 ☐ Married  3XXVidowed 4 ☐ Divorced	1 ☐ Yes 2XXXNo If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify:	White
필	ed	15. Decedent's Edu	ucation	16a. Dece	dent's Usual	Occupation		16b. I	Kind of Business/Ir	ndustry
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4	Com	Grade 12		Home	maker_				own Home	
0 A	Be	17. Father's Name (First, Middle, Last)				_	Name (First, Midd			
ratic	ပ္	John Louis Catts					or Marie			
traum		19a. Informant's Name/Relationship (T)  John F. Breads, J				Street and Number o				
ther		20a. Method of Disposition		Place of Disponentery, cre		pte Lane	Davidsor Date		ocation - City or T	1035-114 Town, State
y or o	Ш	1 X Burial 2 ☐ Cremation 3 ☐ F	Temoval Bulli State			emetery 03	/12/2004		nton, Ma	
important, in term 27 is marked offer their literal, or terms 258 or 2041 and eny injury or other traumatic event, the Maulcal Examiner must be notified at 2005s.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>				Address of Facility		-	incon, Ma	Гутапа
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		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the dea						aryrana	Approximate Interval Betwee
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al-tran	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a conse	quence of):						
the burial-transit	calE		d						Î	
as the			•							
for use as t	Physician/Med	230. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		☐Ectopic pre	nancy			23d. Date of deliv	
ed for	sicis	in the past 12 months? 1 Yes 24 No	4☐ Pregnant at time of		Other (spec				Month	Day Year
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director, page		25.14					1 ☐ Yes	2 XX		<b>2₹</b> }No
= 8	o Be	25. Was case referred to medical examiner?  1 Yes 2 XXo	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie	nt 3 DOA	Other	Death (Check only		CVMthat (Case	Assist
9 9		27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury at Work?	28d. Describe			y Living
eral direc	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, Day rear)	Injury	М	1 ☐ Yes 2 ☐ No				
e funeral direc	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory,	office		(Street a.	nd Number or Run	al Route Number,
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led in by the funeral direct	Certification:	29a. Certifier 1 Certifying Phy	sician: To the best of my kr iner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at vestigation, i	the time, date and p n my opinion, death o	place, and due to the occurred at the time	e cause(s e, date an	s) and manner as s id place, and due t	stated. to the cause(s)
ely filled in by the funeral		(Check only 2 Medical Exami	and manner stated.			License number		29d. Da	ate signed (Month,	Day Year)
ely filled in by the funeral	Medical Cert	one)			29c.	LICOTISC HUITIDGI				ouy, rour/
completely filled in by the funeral direct	edical	29b. Signature and title of certifier	. <b>D</b>							
ely filled in by the funeral	edical	29b. Signature and title of certifier		em 23a) (Type,		D51860			ARCH 1	

State of Maryland / Department of Health and Mental Hygiene 2004 07373 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Biedenkapp **Physician** Year 20 MARgaret 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner + Rehato CtR BAltimor St Elizabeth Nursing If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | S / 18 / 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 220-05-4198 1□M 2MF Mary Land Yrs. Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Madical Examiner: ust be notified at 1 Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 Benson Avenue 21227 Baltimore Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working other than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Important: If item 27 is marked other tt eny injury or other traumatic event, IIIs. once. housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry W. Stubbs Margie A. Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Elizabeth Nursing Home 3320 Benson Avenue Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service Licensee 655 W. Baltimore Street 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
IN UN TILL
J Immediate Cause (Final disease or condition resulting in death) norexia **Physician** /Medical Due to (or as a consequence of): Examiner emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed 2DNo 1 Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33/20 venule Senson 31. Date filed Mobile, Day, Year) 32. Registrar's Signature State Asset. Registrar

State of Maryland / Department of Health and Mental Hygiene ? 07376 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2:30 P M MARCH 3, LINDA CAROL 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 106 CREST AVENUE GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 11 M 2 XX 46 BALTIMORE, MD Director 6/26/1957 215-74-6811 Usuel Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tems 23a or 28a-f shover mad be notified at 1 ☐ Yes 2/ No Director ANNE ARUNDEL GLEN BURNIE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 CREST AVENUE 21061 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be fited within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 ŏ 1 ☐ Yes 2 🛛 XNo Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" er then "nature, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10 OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic svi ဥ ROY BURNOPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 Is y or other tra CURLY BROWN - SPOUSE 106 CREST AVENUE, GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. CLEN HAVEN MEMORIAL PK 3/10/2004 GLEN BURNIE, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign v n T Funeral Service Ucen e 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY TNK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MARYLAND 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Listophy one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 20 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy ò Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) signed by the aid be detached for o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 (X)0 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has lirector, page 2 s autopsy 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) S No Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဥ 2 ER/Outpatient 1 Tyes 3□ DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D16364 MARCH 10, 2004 GATERISON ALMAPOLIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - State Registrar				Certi	tment of h	Death			.2001	4 0737
Physici /Medic		1. Decedent's Nam	e (First, Middle, La: VNE	LES	LIE	BA	EBER		2. Date of Month	D	6 200	3. Time of Deal
Examir	ner	4a. Facility Name (I	- 1	e street and number $NORE$ A				BUK			c. County of De	
Funeral Director		5. Social Security N 216-32-47	702	9X 7. A	ige (In yrs. Ia 68		f Under 1 Year Months Days	If Under 24 H Hours M	n. (Month,	Birth Dey, Year /1935		irthplace (State or For Country) NTUCKY
-f show fied at	tor	Usual Residence of 10a. State MD	10b. County  ANNE AF	RUNDEL	10c. City,	Town or Locat						10d. Inside City Lir 1 ☐ Yes 2
3a or 28a albanot	Funeral Director	10e. Street and Nu	mber MORE AVENUE	E SW			10f. Zip Code 21061			10g. C	itizen of What (	Country?
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	b	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🔀 Married 4 🗆 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	1 Xio		s Decedent of Hes, specify Cub.	dispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or arto Rican, etc.)	No-	Black, Wh	nerican Indian, nite, etc. HITE
n natur	Completed	· · · · · ·	15. Decedent's Ecify only highest gra	de completed)		16a. Deceden (Give kin- life. DO	t's Usual Occup d of work done NDT use retire	eation during most of w	rorking	16b. I	Kind of Busines	s/Industry
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of Health and item 27 is ma r other trauma		WANDA BAF	ame/Relationship (1 RBER - WIFE	Турө, Print)		215 BAL	TIMORE AV	and Number or I				, Zip Code)
nent of Ho ant: If iter ary or oth				Removal from State	э сөл	ice of Disposition metery, cremate I HAVEN M	ory or other plac		Date /04		ocation - City o	
Department of Important: If i any Injury or once.			neral Service Licen	76	)			ss of Facility FI				
			he disease or comp	plications that cause	ed the death.							Approximate
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death.  ctor: After this certificate has been signed by the attending physician and  upp  upp  y the funeral director, page 2 should be detached for use as the burial-transit  and  the funeral director page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examin	Immediate Cause disease or condition resulting in death)  Sequentially list confirmly leading to impact the cause (Disease or that initiated events resulting in death) I  IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 19 Unknown  Part II. Other significations of the cause (Disease or that initiated events resulting in death) I  25c. Was case reference and the cause of the ca	red to medical No  S Pending investigation Could not be determined  Certifying Philipidal Examitation of certifier	Due to (or as b. Due to (or as c. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. Due to (or as d. d. d. Due to (or as d. d. d. d. Due to (or as d. d. d. d. d. d. d. d. d. d. d. d. d.	s a conseque s a conseque s a conseque e of pregnanc 2 Fetal d at time of dea but not resulti  ient 2 Ef ury ay Year) 2 ay Year) t of my knowle of examination tated.	Do not enter the process of the proc	topic pregnancy ther (specify) _  riving cause give  all DOA Oth 28c. Injur Wor 1 _ factory, office  curred at the timingation, in my on 29c. License	en in Part I.  26. Place of Dier: 4 Nursing 4 at  42 No	23e. Di 124a. W 24a. W 24a. W 1 Yes Panth (Check only Home 5 Re 28d. Describ	d tobacco Yes 2 as an topsy flormed? is 22 No. y one) sidence e how inju	23d. Date of de Month  use contribute to death?  24b. Were a prior to death?  1   Ye  6   Other (Spening occurred	elivery Day Year  to the cause of death? Probably 4 Unknow autopsy findings available completion of cause as a No ecify)  Bural Route Number, as to the cause(s)

				partment of Health and Men ertificate of Death		ene .No. 2004 07376
	Physic		Decedent's Name (First, Middle, Last)  Ronald Boyd Bare		ate of Death	Day Yeer 2004 8:30 AM M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)  1208 Bush Road	4b. City, Town, or Location of Death Abingdon	0,	4c. County of Death Harford
Aş.	Funeral Director		5. Social Security Number 210-44-2882  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 50 Yrs.	Months Days Hours Min. (	Date of Birth Month, Day, Y Ot. 14,	
re, maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-1 ahow or other traumatic event, the Medical Exami	To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or 1  Maryland Harford  10e. Street and Number  1208 Bush Road  11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)  Ules Bornie Bare  19a. Informant's Name/Relationship (Type, Print) 19b. Mai 2001  Thelma Bare — Mother 20b. Place of Disc	Abingdon  10f. Zip Code  21009  Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Ricar of Line of Work done during most of working DO NOT use retired)  Wall Installer  18. Mother's Name (First Thelma)  ling Address (Street and Number or Rural Rote of More of Line of Li	Yes or No- n, etc.)  16  st, Middle, Mai  Jean  ste Number, C  Maryl	McMillan  ity or Town, State, Zip Code)
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Records, P.O. Box o	e law requires that the death certif has been signed by the attending te 2 should be detached for use a	Completed by Physician/Media		2	1 Yes	24b. Were autopsy findings available prior to completion of cause of death?
DIVISION OF VITAL	To the Hospital or Attending Physician: The within 2 hours after death.  To the Funeral Director: After this certificate completely filled in by the tuneral director, page	ertification; To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Che ont 3 DOA Other: 4 Nursing Home of 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 28f. L	Residence	e 6 ⊡Other (Specify)  njury occurred  t and Number or Rural Route Number,
	To the Hospit within 24 hours To the Funera completely fille	Medical C	29a. Certifier (Check orly one)  1 Gertifying Physician: To the best of my knowledge, dea control one)  2 Medicel Examiner: On the basis of examination and/or in and manner stated.	29c. License number	the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)
	D-		30. Name and address of person who completed cause of death (Item 23a) (Type	D45390	no	arch 8th, 2004
	Sta Registr		MYO MIN (M. D.) GOZ South Atu 31. Date filed (Month, Day, Year) MAR 1 1, 2004	000d Road # 200	i Bel	Air, mD21014

			1 - For State Registrar	State of Mary			of Health ar of Death		g. No. ZUU	
	Physici /Medic		1. Decedent's Name (First, Middle, La Alberta Fairbro					2. Date of Deat Month	Day Yea	3. Time of Death
	Examir		4a. Fecility Name (If not institution, given Good Samaritan E	Hospital		Balt	wn, or Location of		4c. County of Do	
	Funeral Director			Sex 7. Age (III	n yrs. last birthday) Yrs.	If Under 1     Months   D	Year If Under 24 Days Hours	Min. (Month, Dev.		Birthplece (State or Foreign Country) PW Jersey
	hours after death with the Maryland tural', or Itams 23a or 28a-1 show al Exeminar must be notified at	Funeral Director	10a. State 10b. County  Maryland Balt  10e. Street and Number	timore		en Arm	ode 21057	11	0g. Citizen of What	
9000	172 hours after death with the Marylan "natural", or Items 23e or 28e-1 show olical Executiver care be notified at	by	11633 Glen Arm Ro	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S. 13.	1 ☐ Yes 2 <b>½</b>	t of Hispanic Origin Cuban, Mexican, I No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, W Specify:	Mite
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use i Homemak	done during most o retired)	of working	16b. Kind of Busine:	
	be filed ntal Hygi od other event,	To Be Co	17. Father's Name (First, Middle, Last Godfrev (nmn)			TOHERAK		s Name (First, Middle, M		schman
Maryland	d 2 shouth and h	Ţ	19a. Informant's Name/Relationship ( Alberta B. Bernst	Type, Print)	19b. Maili		treet and Number	or Rural Route Number,	City or Town, State	
Baltimore,	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other <u>once</u> .		20a. Method of Disposition  ↑ Burial 2 Cremation 3 C  1 Donation 5 Other (Special Signature Funers) Service Lice	Removal from State	20b. Place of Dispo cometery, cro Arlingtor 2:	osition (Name matory or othe n Natio 2. Name and A	of or place) onal 3- Address of Facility	Date 2 -19-2004 McComas Fu	20c.Location-City Arlingto neral Hom	on, Virginia ne, P.A.
DESCRIPTION .	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, heading to manage the conditions.	a. Due to (or as a co	e death. Do not en	ter the mode o	f dying, such as ca	d., Abingdo ardiac or respiratory arre		Approximate Interval Batween Onset and Death
8760,	cate be executed oblysician and the burial-transit	Icai Examin	day, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a co	onsequence of):					
P.O. Box 68	that the death certifica ed by the attending ph detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	⊒Ectopic pregr ∃ Other (speci			23d. Date of o	lelivery Day Year
	sign sign d be	by	Part II. Other significant conditions of Africal Arbeitletion,	Contributing to death but n			se given in Part I.	23e. Did tob	/	to the cause of death?  Probably 4 Unknown
Division of Vital Records,		Completed						24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	prior t ned? death	autopsy findings available o completion of cause of ? es 2 □ No
Zii:	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 C 5 B (0		b	Death (Check only one	-	
on of	ding After fune	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury		Injury at Work?	ing Home 5 Resider	nce 6 ∐Other (S <sub>i</sub> w injury occurred	эвспу)
Divisi	al or Attending s after death. il Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	9 Place of Injury	- At home, farm, sti Specify)	reet, factory, or	ffice	28f. Location (Str. City or Town,		Rural Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	h occurred at to	he time, date and i my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
<b>)</b>		M	29b. Signature and title of certifier  ARUN	MATHEWS, M.	0.		ES 000		ARCH 6, 2	
	10		30. Name and address of person who Arun Mathews, MD	completed cause of death			Baltoimor	e, Maryland	1 21239	
	Sta Registr		31. Date filed (Month, Day, Yeer)	32. Registrar's		Nº s				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Jerry Floyd Brady 5:45 A M March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 119 Forestdale Avenue Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9-7-1952 Birthplace (State or Foreign Country) **Funeral** Months 17 M 2□F 217-50-8390 51 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic event, the Marillial Examinar rotat by molified at MD Anne Arundel Severn 1 ☐ Yes 2X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21144 1246 Thompson Avenue USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a says injury or other traumatic event, the Mudical Experience 2008. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel J. Brady Sr. Clara I. Schultz ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Melissa Holman/daughter 1242 Thompson Ave., Sevrn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 3/9/2004 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home M01364 myler 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cayse on each line. Immediate Cause (Final disease or condition Physician ances 22 Month disease or condition resulting in death) /Medical Due to (or as a donsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the funeral director, page 2 should be detached for Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 robably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 NO 1 Yes Hand Be 25. Was case referred to medical examiner? 26. Place of Death Check only one esidence Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient Certification: To 3□ DOA 6 In ther (Specifi this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 3 Suicide 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 To the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5, 2004 39505  $M \cdot D$ 305 Hospital Dr. Glen Burnie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dhish Markan M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	1 - For State Registrar	State of Maryla	-	artment of H			iene	04 0737
Physician	Decedent's Name (First, Middle, La  Jesse	•	hannell			2. Date of Deat Month MARCH (	th Day	3. Time of Death
/Medica Examine	a em the an old at the state of				Location of Death		4c. County	
Funeral Director	214-62-6110	Sex 7. Age (In y	rs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March	<sup>7</sup> 1954	Birthplece (State or Fore Country)     MD
Maryland feet at the state of t	Usuel Residence of Decedent  10a. State  10b. County  Maryland  N/A		City, Town or Lo		ltimore			10d. Inside City Lim 1 ⊠ Yes 2 □ I
with the Mar	10e. Street and Number			10f. Zip Code		. 10	Og. Citizen of \	What Country?
be tiled within 72 hours after death with the Maryland hal Hygiene.  Id other then "natural", or tems 23e or 28e-f show event, I'lle Medical Examinar must be notified at Re-Compiled at Be Compiled at the Co		12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Ì	Was Decedent of His If Yes, specify Cubar	223 spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	ISA e - American Indian, ck, White, etc.  White
filed within 72 hou Hygiene. Other then "natura ent, the Medical E			(Give	dent's Usual Occupa kind of work done d DO NOT use retired) Disabled	uring most of worki	ng	16b. Kind of B	usiness/Industry
2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Marchan	17. Father's Name (First, Middle, Last	wn	40b Maili	ng Address (Street a	18. Mother's Name	<b>}</b>	Hartman	
permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 Is marke any injury or other traumatic once.	Brenda M. Channe  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation, 5 □ Other (Species)  21. Signature of Funeral Service Lice	11 (spouse) Removal from State	304 c. Place of Dispo cemetery, cred letro Cre	Bruce Struction (Name of natory or other place ematory In Name and Address	reet, Bal Marc nc. 20	timore, h 10 04 Stalli	MD 212 20c. Location - Baltimo ings Fu	23 City or Town, State  re, Maryland neral Home, P
The law requires that the death certificate be executed at has been signed by the attending physicien and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner		a. Arteriosc  Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d	lerotic sequence of):					Interval Between Onset and Death
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w requires that been signed t should be deta	Part II. Other significant conditions	contributing to death but not r	resulting in the u	nderlying cause give	n in Part I.			ribute to the cause of death? 3□Probably 4 Unknow
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hysician this certifi al director	25. Was case referred to medical examiner?		XER/Outpatien		4   Nursing Hor	ne 5 🗆 Resider	nce 6 Othe	
ital or Attending Priss after death. The Director: After it and in by the funeral Certification.	27. Manner of Death 1	e Ogo Place of Jajuny At	t home, farm, str	Work′ M 1 □ Y	es 2□No	28f. Location (Str. City or Town,	eet and Numb	ed er or Rural Route Number,
igs nounce ner		nysicien: To the best of my k	knowledge, death	occurred at the time	e, date and place, a	and due to the car	use(s) and ma	nner as stated.
To the Hos within 24 h To the Fur Completely	295. Signature and title of certifier	and manner stated.		29c. License O C M	number	29		(Month, Dey, Year)
5	30. Name and address of person who  J. Laron Locke		tem 23a) (Type.		Street.	Baltimo	re. Mar	yland 21201
State	24 2 MAD -J -7 . 0004	32. Registrar's Sig	nature	9				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For Unpend Item #20b RegistrerAMEND ITEM #20b					2. Date of Death	1	3. Time of Death
/sici ledio		Wayne		Thomas	(	Corbin	Month March	Day Ye 20	04 7:50 A
amir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dea	th	4c. County of D	
		8202 Coastal Highw				an City			rcester
eral ctor		5. Social Security Number 6. Sex 1230 – 27 – 7890	7. Age (In yrs.		If Under 1 Year Months Days	Hours Min		9. 983 V	Birthplace (State or Fore Country) 'irginia
notified at	ctor	10a. State 10b. County  MD Worcest		ty, Town or Loca					10d. Inside City Lim 1 ☐ Yes 2 ☒ I
T Pe UC	I Director	10e. Street and Number 8202 Coastal	Hwv. Apt. 4		10f. Zip Code 21842	)	10	g. Citizen of What	Country?
autre fun	y Funeral	11. Marital Status 1 ⊠ Never Married 2 ☐ Married	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give				Specify Yes or No- to Rican, etc.)		
ICAL EX	ted by	3 Widowed 4 Divorced	Year or Dates:	16a. Decede	nt's Usual Occupa	ation	1	6b. Kind of Busine	Black ss/Industry
event, the Medical	Completed	(Specify only highest grade	College (1-4or 5+)	life. DO	nd of work done of NOT use retired	)	nking		
Ę,		17. Father's Name (First, Middle, Last)			renov	ation 18 Mother's Na	me (First, Middle, Mi		<u>ruction</u>
atic eve	To Be	William	Corbin		r	Patsy	1_	.ou	Taylor
or other traumatic		19a. Informant's Name/Relationship (Tyx) Patsy L Corbin	mother	19b. Mailing	Address (Street a	nd Number or R Ck St. [	ural Route Number, Bloxom VA	City or Town, State 23308	e, Zip Code)
any injury or other tra pnce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)			tion (Name of tory or other place amily Ce		13/1/4	oc. Location - City uilford \	
any inju		21. Signature of Funeral Service License		22. 1	Name and Addres	s of Facility	Stallings d Pasadena	Funeral	Home P.A.
ian cal ner	cal Examiner	23a. Pant. Enter the disease, or compositors, or heart failule. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list and the first any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	nuence of):					Interval Between Onset and Death
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id be detached	by	Part II. Other significant conditions con-	tributing to death but not res	sulting in the und	erlying cause give	n in Part I.			to the cause of death?  Probably 4 □Unknown
╡	e Completed	25. Was case referred to medical				26 Place of De	24a. Was an autopsy performe	prior t ed? death	autopsy findings availat o completion of cause o es 2 \( \square\) No
naile z silon	To B	examiner? 1 X Yes 2 □ No He	ospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe		lome 5 ☐ Residen	ce 6 🕽Other (S	pecify) at scen
naile z silon		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? es 2 🕱 No	28d. Describe how		
turieral director, page z silon	tion	3 ☐ Suicide 6 ★ Could not be determined	3/6/04 28e. Place of Injury - At h building, etc. (Specif	unknown ome, farm, stree y)				et and Number C State 8202 C	Rural Route Number Oastal hwy.
turieral director, page z silon	Certification			wiedne death o	ccurred at the time	e, date and place	e, and due to the cau	se(s) and manner	as stated.
turieral director, page z silon	dical Certification;	29a. Certifier 1 Certifying Phys	cian: To the best of my kno er: On the basis of examina and manner stated.	tion and/or inves	stigation, in my op	inion, death occu	and the time, add		ue to the cause(s)
naile z silon	Medical Certification	29a. Certifier 1 ☐ Certifying Physic (Check only 2 ☑ Medical Examin	er: On the basis of examina	ition and/or inves	29c. License			1. Date signed (Mo	
turieral director, page z silon	edical	29a. Certifier (Check only one)  1☐ Certifying Phys 2☑ Medical Examin	er: On the basis of examina	tion and/or inves	29c. License		290		nth, Day, Year)

Please T

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 2004	07
Certificate of Death Reg. No.	J ,

			1 - For State Registrar	State of Mar		artment of H tificate of L			giene2 () () (4 leg. No.	07381
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic			Karl Crook	(			March	9, 2004	11:44a M
	Examin	er	4a. Facility Name (If not institution, give s 311 Idlewild Roa				Location of Death		4c. County of Dea	
	Funeval				(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Harfo	
b	Funeral Director		215-16-1260	14 005	79 Yrs.	Months Days	Hours Min.	(Month, Day JUL 10		thplace (State or Foreign ountry)
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nation				
	Aaryla r sho	'n			•					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the N	rect	Maryland Harford  10e. Street and Number		Be	1 Air		1	0g. Citizen of What C	ountry?
	h with	Funeral Directo	311 Idlewild Road			2101	L4		USA	
	г деат	ner		2. Was Decedent Ev Amed Forces?	er in U.S. 13. V	Vas Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto F	city Yes or No-	14. Race - Ame Black, Whi	
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give		☐ Yes 2X No		,	Specify: [V]	
8	72 hours after death with the Maryland natural', or Iteme 23a or 28e-1 show disal Examiner must be notified at		15. Decedent's Educ	Year or Dates:	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Business	/Industry
215	thin 72 B. Medi	Completed	(Specify only highest grade	College (1-4or 5+)	life, L	kind of work done d OO NOT use retired;	uring most of working	g		•
7	ed wil	Con		5+		ram Manag	,		Addictions	Treatment
and	ntal Hedol	Be	17. Father's Name (First, Middle, Last) William Howard Cr	ook			18. Mother's Name Kather		Maiden Sumame) Zori	1
ž	thould id Mer mark matic	은	19a. Informant's Name/Relationship (Type		19h Mailin	a Address (Street a			, City or Town, State,	
S	nd 2 suith an alth an 27 is		Valerie S. Crook/w			dlewild F		Air, MI		Lip Code)
ore,	s 1 a of Hea		20a. Method of Disposition		20b. Place of Dispos		Di		20c. Location - City or	Town, State
Ē	Page ment c ant: If ury or		1 ☐ Burial 2 🔁 Cremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro Cre	matory, I	nc. 3/10/		Baltimore,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28e-1 show any injury or other traumatic event, the Medical Examena manual be collined at once.		21. Signature of Funeral Service License  Dawn F. HcDon	e mald	$\frac{1}{2}$	Name and Address remation 99 Freder	s of Facility Society of ick Road	of Maryl Baltin	land, Inc. nore, MD 21	228
. ;	35%		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the cause on each line.	ne death. Do not ente	er the mode of dying	, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	<u>-</u>	Squame	n along	en of No	rek		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					1/10/100
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a o	consequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events							
oʻ	e exectan an an arial-tr	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
8760,	cate be executed by sician and the burial-transit	dicai		-						
Box 6	as as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of	pregnancy				23d. Date of de	incon
ĕ.	that the death cer ed by the attendin detached for use	iclar	in the past 12 months?	1☐Live birth 2 i 4☐Pregnant at tin		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the by the tache	hys	9 Unknown	9∐ Unknown						
ŝ	w requires that s been signed b should be det	ρ	Part II. Other significant conditions con	tributing to death but	not resulting in the up	derlying cause give	n in Part I.		pacco use contribute to	
ord	requir	eted	CANTONIC (	ynragg	re au	pore		1 Ye	s 2 No 3 P	obably 4 Unknown
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ē	ician: Th	e Co	25. Was case referred to medical					perform		2 No
Ē	ysicia s cert direct	0 B	evaminer?	ospital:	2 ER/Outpatient	3□ DOA Othe	26. Place of Death  1. 4  Nursing Hom		e ince 6 □Other (Spe	cifu)
0	Attending Physician: r death. ector: After this certifics by the funeral director, p	n: T	27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day Y		28c. Injury Work		/ .	w injury occurred	ony,
Siol	death. ctor: Af	catic	2 Accident investigation	,,,	,,,		es 2 🗆 No			
Division of Vital Records,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	r - At home, farm, stre (Specify)	et, factory, office	21	8f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Ce	Check Gilly 2 Medical Examini	er: On the basis of ex	xamination and/or inv	occurred at the time	e, date and place, ar	nd due to the ca	iuse(s) and manner as ate and place, and due	stated.
	To the within 2 To the comple	Med	one) 29b. Signature and ritle of certifier	and manner state	a.	29c. License			9d. Date signed (Mont.	
,			They Cell	w	WI)	03	10/07		3/9/20	07
	12		30. Mame and ad ress of person who cor	npleted cause of dear	th (Item 23a) (Type, F	Print) Phan	Q550	BAI	Tome no	21204
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's		NO .	)	VI	-/	
	Registr	ar	MAR 1 1 2004	Ro.	Le Ann	466				

DHMH 17 Rev 1/2001

Michael Chaplin 04-1652 AKG

Baltimore, Maryland 21215-0036

	ľ	For State Registrar			state of	Maryla	and / De	epartm Certific	ent of F	Death	and M	lental Hy	Reg. No		04	,	382
Physicia /Medic		Decedent's Name	e (First, Middle			СН	APLIN					2. Date of De Month March	eath 6, Day	004	Year	3. Time of 3:57	Death A M
Examin	er	4a. Facility Name (#		. •	et and numb	oer)			City, Town, c alisbu		of Death			County			
Funeral Director		5. Social Security N 344-70-4092	2	6. Sex	2□F 7.		rs. last birthe	Mon	nder 1 Year ths Days		Min.	8. Date of Bi (Month, Di 10/02/1				olace (State of otry) COMB ILI	
the Maryland 28a-t show	tor	Usual Residence of 10a. State MARYLAND	f Decedent  10b. County  WICOMI	CO		10c.	City, Town o	or Location SBURY						·	1	0d. Inside C	-
death with the Maryland ms 23e or 28e-t show	al Director	10e. Street and Nur 904 RUSS	mber SELL AVEN	<b>I</b> UE			·	1 Of	. Žip Code	21801			_	izen of W	/hat Cou	ntry?	
s after or Ita	by Funeral	11. Marital Status  Na Never Marri  3 Widowed			Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? <b>(X</b> No	U.S.		ecedent of H specify Cuba s XX No	dispanic O an, Mexica Specify		ecify Yes or No Rican, etc.)	0-		k, White,	an Indian, etc.	
	Completed	(Spec	15. Decedent cify only highes andary (0-12)	st grade co		or 5+)	16a. D	ecedent's l Give kind of fe. DO NO	Jsual Occup work done Tuse retire	during mo	st of work	ing	16b. K	ind of Bu	siness/In	dustry	
lled tygi her nt,	Ве Соп	12 17. Father's Name						ELECTR	ICIAN	18. Moth	ner's Name	(First, Middle		CONSTI Sumame		ON	
as 1 and 2 should be to the following the fo	ToB	LAVON E	EUGENE CH		Print		10h A	Aniling Add	ross /Stroot	and Atumb		JUNE SM		Town 1	Chata Tie	C-4-1	
and 2 significant and 2 significant and 27 is referenced to the contraction of the contraction and the con		JUNE CHAF		, , , , ,	riint)							LINOIS 6		r rown, s	State, Zip	Code)	
permit. Pages 1 and 2 Department of Health a Importent: It item 27 li any injury or other tra ans.		20a. Method of Diss 1XXBurial 2   4 □Dopation	☐ Cremation		oval from Sta	ate	Place of D cemetery, RESCENT	crematory	or other plac	. 1		2004				wn, State	)IS
permit. Departn Importe any inju			CRECORY	1-1	_l_ #M01	1148			e and Addre			INK FUNE LEN BURN	RAL HO	OME, I	PA		
be bur	edicai Examiner	23a. Part 1 Enter it shock or hea Immediate Cause disease or condition resulting in death)  Sequentially list conif any, leading to impresse or that initiated events resulting in death) I	(Final on inditions, nmediate ortying injury s	a b c d	Due to (or	as a consi	equence of)	Jah				r respiratory a				Approximati Interval Beh Onset and I	ween
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									2	23d. Date of delivery Month Day Year			'ear		
w requires that the di been signed by the should be detached	þ	Part II. Other signif	ficant condition	ns contrib	outing to deat	h but not re	esulting in th	ie underlyir	ng cause giv	en in Part	l.	23e. Did t		V	bute to th	e cause of d	
icien: The law re certificate has bee rector, page 2 sho	Completed											1 Yes	psy ormed? 2 \( \square\) No	pr	ior to cor	osy findings anpletion of ca	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certific completely filled in by the funeral director,	ation; To Be	25. Was case reference aminer?  The Yes 2  27. Manner of Death 1 Natural 2 Accident	No h 5 Dending investig	g ation	1 ∐ Inp 28a. Date of I		ER/Outpa 28b. Tim Inju	e of	DOA Othi 28c. Injun Word 1	er: 4□N	ursing Hor	ne 5 Residente R	dence 6	2121		) At s	cene
tal or Atters after de el Directo	Certification	3 🗍 Suicide 4 🗎 Homicide	6 Could r determi	not be ined 2	28e. Place of building,	Injury - At , etc. <i>(Spe</i> c	home, farm cify)	, street, fac	tory, office		2	28f. Location ( City or Tox			r or Rura	Route Numi	ber,
the Hospinion 24 hour the Funer	edical	One)	2KMedical 8	g Physicia Examiner:	an: To the be On the basi and manner	s of exami	nowledge, d nation and/o	eath occur r investiga	red at the tin tion, in my o	ne, date ai pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) date and	and man place, ar	ner as st nd due to	ated. the cause(s)	
To To t	Z	29b. Signature and	title of certifier	a	lon.		Il.	his	29c. License	.E.			Ma	rch (	6, 2		
\		30 Name and addre	ess of person	who comp	LIGA-	tol	em, 23a) (Ty	pe, Print)	11 Per	nn St	reet	, Balti	more	, Ma	ryla	nd 212	01
Stat Registra		31. Date filed (Mon	th, Day, Year	004	32. Reg	istrar's Sigi	hâture	wells)									

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Ma	arylar		irtment of l				giene , Reg. No. C	2004	07383
	是海 多性		Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time of Death
	Physici /Medi		William Kendall	Cleek						Month March	Day 5. 20	Year O.	3:07 P M
	Examir		4a. Facility Name (If not institution, give s				4b. City, Town,	or Locatio	n of Death	March		ounty of Death	
			Greater Baltimore	Medical (	lente	r	Towson				Ba	1timore	2
	Funeral		Social Security Number 6. Sex	7. Ag		last birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bir (Month, Da	th		place (State or Foreign untry)
7.6	Director		214 86 7457 1 x	M 2□F 4(	)	Yrs.	Months Days	Hours	Will.	July 17		Balti	more, Maryland
	pus *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Loc	ation						401 1-14-01-11-1
	anyla	j					alion						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto	Maryland   Baltimore C	ity	GOV	<i>r</i> ans	T						X
	with	Ö	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Cou	intry?
	eath	Funeral Director	5423 Willownere Way	2. Was Decedent	Ever in 11	S 12 W	21212	lianania (	Deinin 2 /Cn	N-	USA		h - d'
$\leq$	iter d	'n	1 Never Married 2 Married	Armed Forces?			Vas Decedeni of P Yes, specify Cub	an, Mexic	an, Puerto	Rican, etc.)	. 14	. Race - Ameri Black, White,	, etc.
	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specif	y:		S	pecify: Whi	te
Ui   \iQy	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lites! Examirat must be notified at	Completed	15. Decedent's Educ	ation		16a. Deced	ent's Usual Occup	pation			16b. Kind	of Business/Ir	ndustry
215	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	and of work done O NOT use retire	during mi d)	ost of work	ing			
$\sim$ $\approx$	gien gien er th	Con	12	N/A	,	Technic	al Enginee	r			Loide	rman & A	ssociates
and	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mot	her's Name	e (First, Middle,			
\alpha \alpha	Ment Ment arked	인	William Kendall Cleek					Mary	Evely	n Davis			
lan	2 sho and ls m		19a. Informant's Name/Relationship (Type	e, Print)			g Address (Street			al Route Numbe	er, City or T	own, State, Zip	o Code)
(D)	and eaith n 27		Timothy A Knight				oland Heig	hts A	ve. B	altimore,	Md. 2	1211	
Q 20	of H of H If ite		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Re	amoval from State	20b. F	Place of Dispos cemetery, crem	ition (Name of atory or other pla	ce)	[	Date	20c. Loca	tion - City or To	own, State
$C \mathcal{C} $	Pag ment tent: jury o		* 4 □ Donation 5 □ Other (Specify)		Met	ro Crema	tory Inc.	March	9 200	4	Baltim	ore, Mary	land
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It's Medical Examinat must be notified at once.		21. Signature of Funeral Service License	θ ΟΛ	-	122. Ta	Name and Addre	ss of Fac	ility nmo Tny				
	70 = 4 O		MUNTOU CLOSE	n Chan	ock	1 /4	J1 Belair	Road 1	Baltim	ore. Marv	land 2	1236	
6			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused e cause on each lin	the deat	h. Do not ente	r the mode of dyir	ng, such a	s cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	isch	emi	æ							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as									
- 54	LAUMMEN	_	Sequentially list conditions, b.	nyp	OXIC	ì							
-	pe #s	Examiner	Sequentially list conditions, any loading to minudiate cause. Enter Underlying Cause (Disease or injury	Due to or as	a conseq	uence of):	-						
_	and I-tran	хап	that initiated events c. resulting in death) Last	Due to (or s	a consec	NOC	\					_	
8760,	be ex				,	in.							
387		dical	d.	PILE	um	onia							
×	Physician: The law requires that the death certificate has been signed by the attending this certificate has been signed by the attending rat director, page 2 should be detached for use as	by Physician/Me	IF FEMALE:	c. If yes, outcome	of preona	incv			11/2				THE PLANTS
Bo	atter for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Feta	I death 3 □{	Ectopic pregnancy Other (specify)	1			230	<ol> <li>Date of delive Month</li> </ol>	ery Day Year
o.	that the deed by the	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		50	Ollier (apacity)						
σ.	es that thighed by be detac	y P	Part II. Other significant conditions cont	ributing to death bu	ut not res	ulting in the und	derlying cause giv	en in Part	1.	23e. Did to	bacco use	contribute to the	he cause of death?
ds	uires sign id be		pneumoth	orax						1 🗆 Y	es 2 X	lo 3⊟Prot	pably 4 Dunknown
<u> </u>	w requir	lete								24a. Was a		Idh Mass sute	
Re	The law cate has	Completed								autop	sy maed?	prior to co	ppsy findings available mpletion of cause of
<u>a</u>	ician: Th certificate ector, pag	ပိ	25. Was case referred to medical							1 Yes	2.2(No	1 🗆 Yes	2 No
S	ysician: is certific director,	o B	examiner?	ospital: 1 X Inpatie	at o	FD/Outpations	3 DOA Oth			(Check only or			
o	Phys or this oral di	$\vdash$	27. Manner of Death	28a. Date of Injur	v	ER/Outpatient 28b. Time of	JU DON	4 🗆 🗅	-	me 5 Resid 28d. Describe h			y)
77 6	th. : After funer	it or	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	28c. Injur Wor M 1	k? Yes 2∐			· · · · · · · · · · · · · · · · · · ·	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Vital Records, P.O. Box	Attending ar death. ector: After by the funer	Hice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ıry - At ho	me, farm, stree	et, factory, office		1	28f. Location (S	treet and N	umber or Rure	al Route Number,
Ō	To the Hospital or Attent within 24 hours after deall To the Funerel Director: completely filled in by the	Certification:	4   Homode	building, etc	: (Брөсіт)	/)				City or Tow	n, State)		
	To the Hospital or within 24 hours after To the Funerel Dit completely filled in		29a. Certifier Certifying Physi (Check only 2 Medical Examin	cian: To the best of	of my kno	wledge, death	occurred at the tin	ne, date a	ind place, a	and due to the o	ause(s) and	d manner as s	tated.
	the H in 24 the F splete	Medical	(Check only 2 Medical Examinations)	and manner sta	ted.	tion and/or inve	stigation, in my o	pinion, de	ath occurre	ed at the time, o	late and pla	ce, and due to	the cause(s)
	To the Vithin 2 To the Comple	2	29b. Signature and title of certifier		0		29c. Licens	e number	0.0	~ 2	9d. Date s	igned (Month,	Day, Year)
	Į		manhs-1/10	mal	X		DC	05	808	5	3	1610	4
	(2)		30. Name and address of person who con	_	4.4	23a) (Type, P	rint)	0 10	-10	A1 01	1 1	CI	601
	-		Mark S.	Gosne				65	67	1V/CF	tarle	5 7+	PAVILLION
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ır's Signa	Anne	1						WEST

#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Ls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:10 AM 2004 Joseph Charles Collins, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Lorien - Bel Air Bel Air Harford If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Days 1 3 M 2 □ F Months Hours Min. 18, 1926 Tennéssee Director Sept. 439-26-2456 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mantel Hygiene. Importants if flean 23e or 28e-f show Importants if flean or 21e marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as 1 X Yes 2 □ No Directo New Orleans Ouisiana Orleans 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 70119 Funeral 942 Harding Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Allied Foldes: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>US Administrative</u> Law Judge US Government 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aida Mae Triay Collins Joseph Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 Knightswood Ct., Bel Air, MD 21015 Joseph C. Collins III / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-13-04 New Orleans, LA Green Wood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licenses McComas Funerally Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications the sused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each shock, or heart failure. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) a CEREBROVASCULAR ACCIDENT Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as e consequence of) Physician/Medicai that Initieted events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown SUBDURAL HEMATOMA Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ATRIAL FIBRILLATIONS 2/1No 1 L Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: The law raquiras that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after deem.
ai Director: After th To the Hospital within 24 hours a To the Funeral Completaly filled Hospital

end

the Marylend

21215-0020

Maryland

Baltimore,

Registrar

Medical

SURESH DHA 31. Date filed (Month, Dey, Year)

MAR 1 1 2004

29b. Signature and title of certifie

29a. Certifier (Check only one)

770 32. Registrar's Signature

lles aeu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6225. UNION ANE, HAVRE DE GRACE, MD 21078

To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Yeer)

DHMH 16 Rev 6/95

				State of Maryland / Department of Health and Mental Hystate Amend Item 1,31 per Dr/DVR,G829,03/11 Cortillicate of Death	
		Physici	ian	1. Decedent's Name (First, Middle, Last) Paul Joslyn Chrzanowski.  2. Date of D  Month  O 3	
4		/Media	cal		05 2004 13 34 pm
	1	Examir	ner	4a. Facility Name (If not institution, give street and number)  HARFORD MEMORIA HOSPITAL HAVRE DE GRACE	4c. County of Death  HARFORD
		Funeral	Г	5. Social Segurity Number 6. Sex 7. Age (In /s. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of B	
		Director		017–38–3388 1¼ M 2□F 57 Yrs. Months Days Hours Min. (Month, Days July 1	31, 1946 Massachusetts
6		pur k		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d Incide City Contra
		Aaryla sho	ō		10d. Inside City Limits 1X Yes 2 □ No
		the N	Director	Massachusetts Berkshire Great Barrington  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
		3a or	٥	317 State Road 01230	USA
		death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
M	9	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No   1 ☐ Yes 2 ☐ No   Specific	Black, White, etc.  Specify:
d	00	hours ural',	d by	3 Wildowed 4 Proceed Year or Dates:	White
7	15	n 72	lete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business/Industry
3	212	iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  2 Civil Engineer	State Highway Dept.
3.	ď	should be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or Items 23a or 28a-f show imatic event, It a Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle)	
1	/lar	should be ind Mental s marked o	To E	Herman (nmn) Chrzanowski Gladys Marie	Joslyn
	Maryland 21215-0036	2 6 8 8		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number)	
*	°.	and ealth a 27		Matthew Chrzanowski / son 70 Ontario St., Pittsfield,	
7	Baltimore,	Pages 1 nent of H unt: If iten ury or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
10	Ħ			*4 □ Donation 5 □ Other (Specify) Elmwood Cemetery 3-11-04  21. Signature Funeral Service Licensee 22. Name and Address of Facility	Great Barrington, MA
15	Ba	permit. Departr Imports eny inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abino	don, Maryland 21009
3				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line.	arrest, Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition resulting in death)  a.   MYOCARDIA THEARCTION	Onset and Death  UNLNOWN
	1	/Medical Examiner		Due to (or as a consequence of):	-0/
			er	Sequentially list conditions.  b. STEXOSIXO CORONARY HITHEROS frany, leading to immediate  Due to (or as a consequence of):	216ROSI)
		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  C. AS	
-	o,	be executed sician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	
$\mathcal{C}$	3760,	ate be ex hysician the buria	Ical	d	
0	9 ×	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE:	
d.	Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery  Month Day Year
-	P.O.	uires that the de n signed by the a ld be detached f	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown	
V		that I	y Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death?
S	rds	quires n sigr uld be	ed by	SIP COROHARY ANTERTY STEHTS 10	Yes 2 □ No 3 Probably 4 □Unknown
3	00	law requir as been si 2 should	plet	24a. Was	an 24b. Were autopsy findings available
0	R	The lav	Completed	auto perfc 1 1 ✓ Yes	ormed? death?
2	ita		Bec	25. Was case referred to medical examiner?	
C	<u>~</u>	hysic his ce Il dire	To	1 Yes 2 No Hospital: 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Resi	dence 6 Other (Specify)
7	S LO	ttending Phys death. stor: After this (	lon;	1 Natural 5 □ Pending (Month, Day Year) Injury Work?	how injury occurred
0	Division of Vital Records,	death. death. ctor: A	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (	Street and Number or Rural Route Number,
H	Div	tal or Attenders after death al Director: ed in by the	Certification;	4 Homicide determined determined determined determined determined determined building, etc. (Specify)	
0		To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director, I	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as stated. date and place, and due to the cause(s)
		To the To the Comp	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		1		LLauino fundordo mp Do015466	MARCH 8, 2004
		124		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramiro R. Lindado, MD	01090
		1.		Laurino fundova mp D0015466  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramiro R. Lindado, MD 3205 Rolling Broch Dr - Churchville, MD  31. Date filed (Month, Day, Year)   32. Registrar's Signature	21028
		Sta Registr		31. Date filed (Month, Day, Year) / 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene 07386 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** COLLINS OHN romas MARCH 00: 6 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore City Baltimore
Under 1 Year | If Under 24 Hrs. Hospital Hunkins Whas 8. Date of Birth (Month, Day, Yel 3-21-1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 15 M 20 F Hours Months 578-36-5408 74 Yrs. NC Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location ral, or Items 23a or 28a-f show Examiner must be notified at 1 Tyes 2 No Linthicum Directo Anne Arundel 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 6589 Englewood Road USA 21090 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced "natural", Completed other than natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Computer Science 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event sing. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lena Elizabeth Gill Leo Thomas Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Virginia L. Collins/wife 6589 Englewood Road, Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/9/04 Elkridge, MD \* 4 □ Donation 5 □ Other (Specify) Meadowridge Cemetery 21. Signature of Juneral Service License 22. Name and Address of Facility Singleton Funeral Home M01364 1 Second Ave SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS SYSTEM MULTI /Medical Due to (or as a consequence of) Examiner SEPTICEMIA

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-transit NEUMONIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Appatient Other: 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) : After thi 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 LES Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 600 NORTH WOLFE STREET JOHN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar 07387 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Cody Joseph Clifton March 2004 1:50 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 715 Maiden Choice Lane Apt. CR214 Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 19, 1 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days 1**X**M 2□ F Hours 216 14 8615 Director 82 1921 Louisiana Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location rel', or itams 23a or 28a-f show Examiner coust be molified at 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt. CR 214 21228 U.S. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permil. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itan any injury or other traumatic event, the Medical Experimentation. 1 X Yes 2 □ No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Guager 12th Sun Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Clifton Judith Romagas ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Ashton / Daughter 2 Capps Court Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 3/8/2004 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Þ Baltimore, Maryland 21225 Part1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TA EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the ald 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uf)known peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 No To the Hospitel or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 hesidence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA o this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division Injury 1 Aatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN ARRETT 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 1 2004 Registrar

			For State Registrar	State of Marylan		rtment of F			ne 10.2004 073	88
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last OPAL  4a. Facility Name (If not institution, give Mercy McCl	Street and number) CA ( CCM)	EY	Balti		2. Date of Death Month	Pay Year 3. Time of Death N/A	- 1
	Funeral Director		5. Social Security Number 6. Se 404 16 8069	7. Age (In yrs. ) 7. Age (In yrs. )	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea July 26,	1919 Sentucky  Sentucky  1919 Rentucky	Foreign
	the Maryland 28a-f show	rector	10a. State 10b. County Maryland N/A  10e. Street and Number		y, Town or Loca			100.0	10d. Inside City 1覧Yes 2 Citizen of What Country?	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, I'le Maulcal Examiner must be notified at once.	by Funeral Director	524 N. Charles S  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	S. 13. W	2120	O1 ispanic Origin? (Sp nn, Mexican, Puerto Specify:		U.S.  14. Race - American Indian, Black, White, etc.  Specify: White	
121215-0036	d within 72 hour giene. er than "natural , the Maulcal E.	Completed t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	Year or Dates: (cation e completed)  College (1-4or 5+)	(Give ki life. Di	nn's Usual Occup ind of work done O NOT use retired er Fille	during most of work ()	king	Kind of Business/Industry eads Warehouse	
Maryland	2 should be filed and Mental Hygis Is marked other sumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Jennings  19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street	Ti1	e (First, Middle, Maide da May al Route Number, City	en Sumame) or Town, State, Zip Code)	
	Peges 1 and 2 nent of Health a ant: If item 27 Is ury or other trau		Charles Conley  20a. Method of Disposition  1  Burial 2 Cremation 3 F	Removal from State	2606 P lace of Disposi	opler Dr tion (Name of atory or other place	rive Ba	ltimore, M	aryland 21207 Location - City or Town, State	
Baltimore,	permit. Pe Departmen Importent: any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		22.	Name and Addres	ark   3/12, ss of Facility Go ie Highwa	nce Funera	n Burnie, Maryla 1 Service, P.A. Ore, Maryland 2	
8760,	death certificate be executed  Medical Examine and physicien and of for use as the burial-transit	dicai Examiner	28a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence).	Jence of):	the mode of dyin  Wel  (CX 11	0135		Approximate Interval Between	en
.O. Box 6	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	ctopic pregnancy Other (specify)	-		23d. Date of delivery Month Day Yea	ar
Records, P.	w requires that been signed to should be deta	by	Part II. Other significant conditions cor	ntributing to death but not resu	liting in the und	erlying cause give	en in Part I.	23e. Did tobacco	use contribute to the cause of dea	
	ysicien: The law r is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	24b. Were autopsy findings average prior to completion of cause death?  1  Yes 2 No	ailable se of
Division of Vital	ding Ph h. After th funeral	Certification: To B	examiner?  1 Yes 2/17 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ER/Outpatient 28b. Time of Injury		er: 4 □ Nursing Ho at ?? ∕es 2 □ No	me 5 Residence 28d. Describe how inju	ury occurred	- 1
Div	in the		4 Homicide determined  29a. Certifier Check only 2 Medical Examir	building, etc. (Specify,	vledge death o	occurred at the tim	e date and place	City or Town, Stat	c) and manner as stated	,
!	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29b. Signature and title of certifier	and manner stated.	on and/or inves	29c. License	number		ate signed (Month, Day, Year)	·
	Sta Registr		30. Napre and address of person who co	mpleted cause of death (Item  1 3015711	9UL-1-			tmore,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMFND ITEM #8 PER FH G829 3/11/04 JEC ertificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1840 PM March 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimone Bal Sinai tal imore 0) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1 29, 1904 Birthplace (State or Foreign Months | Days | Hours | Min. | Month, Day | Mary | Country) (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F 1616 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow other traumetic event, the Medical Examinar must be notified at Director 1 XYes 2 No Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Itema 23a or 163 21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) omest Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) grande might, 19b. Mailing Address (Street and Num. er or Rusal Rout, Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or others Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ aine 21. Signature of Funeral Servicense 22. Name and Address of Facility any is Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Sepsis 14 day /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of April 1) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 3 Probably 1 Tyes 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Extremi this certificate 1 ☐ Yes 2 ☐ NO 2 No To the Hospital or Attending Physicien: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Mpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the negative within 24 hours after death.

To the Funerel Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number RES - 00C 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai MD HOSP

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Year)
MAR 1 1 2004

32/Registrar's Signature

_			For State Registrar	State of Ma	ryland /	Depar Cert	rtment of	Health <i>Deatl</i>	and M	F	Reg. No.	2004	
	Physici /Medic		Decedent's Name (First, Middle, La     MARGARET MARY December 1.1							2. Date of Dea Month	Day	2004	3. Time of Death 6:35 P, M,
	Examin	_	4a. Facility Name (If not institution, give NORTH ARUN	11	PITA	12 (	4b. City, Town, GLEN	Bu	IRNI	E	An	Ounty of Deat	FRUNDEL
	Funeral Director		5. Social Security Number 6. S 216-28-9146	I M AFRE	(In yrs. last)	Yrs.	Months Days		Min.	8. Date of Birt (Month, Da) JULY 18	h y, <i>Year)</i> , 1932	Co	hplace (State or Foreign untry) TIMORE, MD
	death with the Maryland ms 23a or 28a-f show finant be notified at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, To								10d. Inside City Limits 1 ☐ Yes 2XXNo
	or 28a-f	Director	MARYLAND ANNE AI  10e. Street and Number	RUNDEL	GLE	EN BURN	10f. Zip Code				10g. Citiz	en of What Co	untry?
)	leath w	erail	715 OLD STAGE ROAD	12. Was Decedent Ev	ver in U.S.	13. W	as Decedent of Yes, specify Cui	1061 Hispanic C	rigin? (Spe	cify Yes or No-		S.A. 4. Race - Ame	rican Indian,
577	hours after o tural', or iten	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Yes, specify Cui			Rićan, etc.)		Black, Whit Specify:	e, etc. VHITE
DORDS 21215-003	within 72 ho ene. then "natur ce Medical	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+		(Give k life. D	ent's Usual Occu ind of work done O NOT use retire	during me	st of worki	ng	16b. Kin	d of Business/	•
NAKGARET Baltimore, Maryland 2	be filed tal Hygi d other	To Be Co	12 17. Father's Name (First, Middle, Last WILLIAM McDEVITT	)		h	HOMEMAKER			(First, Middle,	Maiden S	OWN HOME	<u>-</u>
lary	2 should and Men Is marke	-	19a. Informant's Name/Relationship		1		Address (Stree	t and Num	ber or Rura	l Route Numbe			
, 5.	s 1 and F Health Item 27 other to		DENNIS DOROSZ - So 20a. Method of Disposition		20b. Place	of Dispos	OLD STAGE ition (Name of atory or other pla			BURNIE,		AND 21061 ation - City or	
子島	Page: ment o tant: If jury or		1 🖾 Surial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci		1	IAVEN N	MEMORIAL I	PK	3/12/2			GLEN BUF	RNIE, MD
is Ball	per it. De artr Import. en; inj		21. Signature of Funeral Service Lice KELL LineGONY	EMY () JM01		426	Name and Addr 5 CRAIN H	GHWAY	S., GL		E, MAF	-	061
•	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final) disease or condition resulting in death)	a. Due to (or as a	atic	DV	the mode of dy		s cardiac o		rest,		Approximate Interval Between Onset and Death
8760,	ing 1.1	icai Examiner	Sequentially list conditions, it any, leading to an modate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence	e of):	A .						
P.O. Box 68	ath certific ttending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 20 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal dea		Ectopic pregnand Other (specify) <sub>=</sub>	су			2:	3d. Date of del Month	ivery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions	contributing to death but	not resulting	g in the und	derlying cause g	ven in Par	1.		obacco us		the cause of death?
al Records,		Completed	1							24a. Was autop perfor 1 Yes	sy	24b. Were au prior to death? 1 \( \text{Yes}	topsy findings available completion of cause of 2 No
Vita		o Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 Inpatien	t 2□ER/	Outpatient	3□ DOA O	han		ne 5 Resid	111	Other (Spe	eifv)
Division of Vital	fune	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Late of Injury (Month, Day	288	. Time of Injury	28c. Inju		1	28d. Describe h			,,
Divis		Certification:	3 Suicide 6 Could not to determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stree	et, factory, office			28f. Location (S City or Tow		Number or Ru	iral Route Number,
1	the Hospitel or hin 24 hours after the Funerel Dir npletely filled in	Medicai	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysicien: To the best of miner: On the basis of e and manner state	examination	lge, death and/or inve	occurred at the estigation, in my	ime, date a opinion, de	and place, a ath occurre	and due to the ded at the time, d	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within To the compt	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date	signed (Mont	n, Day, Year)
			30. Name and address of person who	completed cause of dea	ath (Item 23	a) (Type. P	Print)	347	/		Nav	th 8	2004
_	V		Ayoka Drojing	1 301 Hr	zerty	DRI	ve ili	len	Sun	re. 1	M	2/06,	<u> </u>
4	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar	rs Signatude	selfe.							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 0.0

			For State Registrar		State of N	narylar	та / Depa Се:	artment of i rtificate of	neaith ar <i>Death</i>	na Men		giene Reg. No.	2004	07391
	Dhusis		Decedent's Name (First,)	Middle, Last)							Date of Dea		Voor	3. Time of Death
	Physic /Medi		Sophie Eli	zabeth	Dailey						March	6	200 4	3:05AM
	Examir	ner	4a. Facility Name (If not inst					4b. City, Town,				4c.	County of Dea	th
			Sinai Hosp 5. Social Security Number	0/ (A/ C			last birthday)	If Under 1 Year	MOY €			<u> </u>	O Pie	halona (Chata a E
	Funeral Director		213-01-3287 Usual Residence of Decede	1 🗆		35	Yrs.	Months Days		Min. 06,	pate of Birt Month, Day 115/1	918		hplace (State or Foreign ountry) Yland
	yland 10W		10a. State 10b. Co			10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	tor	MD Howa	rd		Colu	umbia							1 □ Yes 2 XNo
	th the	Directo	10e. Street and Number					10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	ath wi	ral	7070 Cradlero	ck Way				21045					USA	
	ter dea Items	Funeral	11. Marital Status		<ol> <li>Was Deceder Armed Forces</li> </ol>	?	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin an, Mexican, F	n? (Specify Puerto Ricar	Yes or No- n, etc.)	. 1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, Ira Mudical Evertinet must be notified at Ance.	by	1 ☐ Never Married 2 ☐ 3 🖫 Widowed 4 ☐ Div		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	: •		1 ☐ Yes 2 💢 No	Specify:				Specify: Wh	ite
5	"nati	Completed	15. Dec (Specify only i	edent's Educ nighest grade	ation completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	f working		16b. Kin	nd of Business/	Industry
272	withir ene. than	dmo	Eiementary/Secondary (0	-12)	College (1-4o	r 5+)	Homema		10)			~ ·	7 <b>.</b>	
	Hygid other ent, I	Be C	17. Father's Name (First, Mi	ddle, Last)			nomenia	rver	18. Mother's	Name (Fire		Own Maiden		
Maryland	should be fund Mental h	To B	John Reining	er					Marie 7	Tilger	•			
ary	2 shou and N Is ma	-	19a. Informant's Name/Rela	tionship (Typ	e, Print)		19b. Mailir	ng Address (Stree				r, City or	Town, State, 2	Zip Code)
	and and and no 27		Thomas F. Dai	ley/so	n			Tiller D		llicot	t Cit	ty, I	Md. 210	42
ore	Pages 1 nent of Ha ant: If iter ury or oth		20a. Method of Disposition 1 Durial 2 ☐ Crema	tion 3 □Re	moval from Stat			sition (Name of natory or other pla		Date		20c. Loc	cation - City or	Town, State
E,	: Pag tment tant:		`4 Donation 5 □ Oth	er (Specify)		Lou		rk Cemet					imore,	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Magnes.		21. Signature of Funeral Se	fvice License	1. M	lle		. Name and Address	ess of Facility V Knolls	Witzk∈ Rd.,C	Fune Columb	eral	Homes, Md. 21	Inc. 045
	- 11		23a. Part1. Enter the diseas shock, or heart failure.	se, or complic List only one	ations that cause cause on each	ed the deat							333.0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Muo	aro	liali	nfare	tion					Onset and Death
П	/Medical Examiner		resulting in death)		Due to (or a	s a conseq	uence of):	nfare						
*	LAGITITIES	_	Sequentially list conditions,	b.	Due to fee									
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6	axecul and al-trar	Examiner	that initiated events resulting in death) Last	c.	Due to (or a	s a conseq	uence of):							
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	tificat ng phy as th	Aedical												
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnal in the past 12 pronths? 1 Pyes 2 No 9 Unknown	11.	c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у			23	3d. Date of deli Month	very Day Year
<u>α</u>	res that igned by be deta	by Ph	Part II. Other significant co	nditions cont	ributing to death	but not res	ulting in the u	nderlying cause gr	ven in Part I.	2	23e. Did to	bacco us	se contribute to	the cause of death?
ords	w requires been sign should be	ted b								_ [	1 🗆 Y	es 2 🔽	No 3□Pro	obably 4 Unknown
Il Records,	The faw rate has be page 2 sh	Completed									24a. Was a autops perform	SV	24b. Were au prior to death?	topsy findings available completion of cause of
Vital	Physician: r this certificanal director,	Be	25. Was case referred to me examiner?		spital:			0.4	26. Place of	Death Che	eck on or	пе		
of	Phys this rat dir	To	1 Yes 2 No	110	. 1 Minpat		ER/Outpatien 28b. Time of	1 3 DOA			5 🗌 Reside		Other (Spec	ify)
O	ding h. After fune	tion	1 Natural 5 □ P	ending vestigation	28a. Date of In (Month, D	ay Year)	Injury	28c. Inju Wo M 1	rk?  Yes 2∐No		Jeschbe n	ow injury	occurred	
Division	Atten r deal actor: y the	fica	3 ☐ Suicide 6 ☐ Ç	ould not be	28e. Place of Ir	njury - At ho	ome, farm, str	eet, factory, office	1,00	28f. L	ocation (S	treet and	Number or Ru	ral Route Number,
Ö	s after at Dire	Certification:	4 Homicide		building, e	itc. (Specify	y)			0	ity or Town	n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Physi licel Exemine	cian: To the bes er: On the basis and manners	of examina	wledge, death tion and/or inv	occurred at the tirestigation, in my	me, date and p ppinion, death o	place, and di occurred at	ue to the c the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of ce	ertifier				29c. Licens	se number		2	9d. Date	signed (Month	. Day, Year)
	1		1.41	Des	ulua	M.D	1,	000	2472	6		R	March	6 2004
	V		30. Name and add es of p	son who om	pleted cause of	death (Item	23a) (Type,	Print)						
			Alejanka 31. Date filed (Month, Day,	10 5	EQUE	IRA.	2401W	est Belve	dere Ave	e Bal	time	10,1	Marylan	d 21215
	Sta Registr		31. Date filed (Month, Day,	1 2004	3a Hegis	rars Signa	The state of the s	sele!						6 2004 d 21315

			For State	State of Maryland /	Department of Health and Certificate of Death	Mental Hygier	000:	
			Registrar  1. Decedent's Name (First, Middle, Last	)		2. Date of Death	3. Time of Death	
_	Physi		Robert	ROLAND	DUGAS	Month MARCH	9 2004 04=20 M	
	/Mec Exam		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	
	LXUIII		HALFORD MEMO	MAL HOSPITAL	HAUNG DE	GRACE	HAZCOND	
	Funera	ı	5. Social Security Number 6. Se	7. Age (In yrs. last t	oirthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)	
	Directo	r	038-18-4519	TM 2DF 74	Yrs.	May 22,1	1929 Country) Mass	
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City. To	wn or Location		10d. Inside City Limits	
	ahor shored	5		1	Aberdeen		¥es 2 □ No	
	the N	Director	10e. Street and Number	Ford	10f. Zip Code	10g (	Citizen of What Country?	
	with or an	급	14 11.1000		2)001	1	154	
	leath	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,	
5	fer c	臣	1 Never Married 2 Married	Armed Forces?		to Rican, etc.)	Black, White, etc.	
6	030 ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒KNo Specify:		Specify: White	
	Ind 21215-0036  be filed within 72 hours after death with the Maryland tall hygiene. Ind other than "naturel", or frems 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation     (Give kind of work done during most of wolf life. DO NOT use retired)	nkina 16b.	Kind of Business/Industry	
	12 14 14 14 14 14 14 14 14 14 14 14 14 14	de	Elementary/Secondary (0-12)	College (1-4or 5+)	\ 8 (	en	Textile	
0	21 Sed w	ြင်	8		Textile	and (First Addition to Admin	TOCKTO	
7	E da E da S	Be	17. Father's Name (First, Middle, Last)		1	me (First, Middle, Maide		
		2	William L	ougas	9b. Mailing Address (Street and Number or R		COLVON	
7	Maryla id 2 should th and Men it is marke traumatic		19a. Informant's Name/Relationship (7)		the second	2:	27.00	
0	- C - N -	1	20a. Method of Disposition	20b. Place	of Disposition (Name of	Horrdeer Date 20c.	Location - City or Town, State	
16	O September		1 Burial 2 Semation 3 I	Removal from State	ery, crematory or other place)	7-04 19	Baltimore, MD	
-	Baltimore, permit. Pages 1 a Department of Hea Importent: If item		* 4 □ Donation 5 □ Other (Specify)  21. Signal 100 □ P neral Service Liceps		22. Name and Address of Facility	, 01	oct minor estino	
(n)	Balt permit. Depart import		Dewol.	March		Mid Valley		
			shock, or heart failure. List only o	lications that caused the death. Do ne cause on each line.	o not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death	
	Priysiciai	_	Immediate Cause (Final disease or condition resulting in death)	a. HASCL	0			
	/Medica Examine		resulting in death)	Due to (or as a consequence	e of):			
^		١.	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequenc	e of):			
7	ted	틸	Cause (Disease or injury	500 10 (01 23 2 50130430110	<b>3</b> 31).			
2	sxecu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequenc	e of):			
<u>.</u>	Records, P.O. Box 68760,  The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d				
,	687 dificate g physi as the	led ed						
0	Box 68 leath certifica attending ph	N/	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 Ectopic pregnancy		23d. Date of delivery	
~	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death	5 Other (specify)		Month Day Year	
	P.O	Å.	9 🗆 Unknown					
1	ds, P.O. I uires that the de signed by the a Id be detached i	Š	Part II. Other significant conditions co	-			o use contribute to the cause of death?	
(	ecord law requir as been si 2 should	ted	014 36 163	MERLITUS I.	911011	1 Y 8 S	2 No 3 Probably 4 Aunknown	
	Recelaw in the base by the 2 st	Completed	SP LEFT C	UA		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
	The The page	2	·			performed? 1□ Yes 2Æ		
~	of Vital Re Physicien: The I this certificate ha	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)		
_	Of Physical this cal dir	<u>ا</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient 2 DAEHV	Outpatient 3 DOA 4 Nursing  Time of 28c. Injury at	Home 5 Residence		
S	Jing I	lo	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury Work?  M 1 Yes 2 No	280. Describe now in	july occurred	
E	ision ttenc death death ctor: / the	cat	3 Suicide 6 Could not be	28e. Place of Injury - At home.		28f. Location (Street	and Number or Rural Route Number,	
9	Division  I or Attending after death. Director: After	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	and the sail that say, since	City or Town, Sta	ite)	
C	Division of to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C			ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ			
	To the Howithin 24 To the Fu	led	one)	and manner stated.	29c. License number		and the same of th	
	To With	Σ	29b. Signature and title of certifier	1 4		29d. Date signed (Month, Day, Year)		
	,1		Jamshin	men m.s	721809	10/14	12649,2004	
	1)		30. Name and address of person who o		1) (Type, Print)  ALIC NOAD T. MON	wide Mr	121093	
		State	31. Date filed (MMA Pry, Year) 20	32 Registrar's Signature	1.MOF	<u> </u>	, = 13	
	Regis		WHILL IT (I)	32 Registrar's Signature	Anost			

State of Maryland / Department of Health and Mental Hygiene 2004 07394 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Month ELIZABETH **ECUYER** March 5. 9:55P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Presbyterian Home of Maryland Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 3, 191 **Funeral** 9. Birthplace (State or Foreign Country) New York 1 M 2 X Director 128-03-5135 87 August 1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Modical Expridibit ...ust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 ☐ Widowed XX Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fand Mental h Morris Hart Sarah Fowler Kinnear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Rhoades 4 Rumford Drive #103 Baltimore, Maryland 21228 DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State rtment of I 1 Burial XXCremation 3 Removal from State permit. Page Department of Important: If any injury or once. Greenmount Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 3/8/04 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21. Signature of Funeral Service Licensee John O. Mitcher 6500 York Road Baltimore, Maryland 21212 23a. Pm1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BEMENTIA **Physician** DENILE ALZHEIMERS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner death certificate be executed transit and burial-1 Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery ō 3 Ectopic pregnancy Month 4 Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ 99 cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No ector. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the } 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 8 2004 030433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21204 M DALY MD GAMC 6701 MO NCHARLE'S 31. Date filed (Month, Day, Year) **MAR 1 1 2004** 32 Registrar's Signature State Registrar

Type of Time in Black machbie ink.	Eliouio Ali	Copies Aic	-03	31010	"
State of Maryland / Department of He	ealth and Me	ental Hygien	e21	00	

			1 - For State Registrar	State of Maryla			of Health a of Death	and Mental H	ygiene $2001$	+ 07395	
	Dhysisi	on.	1. Decedent's Name (First, Middle, Las	0				2. Date of D Month	Day Year	3. Time of Death	
1	Physici /Medio		Alice Z. Eager					March	9 2004	12:30AM	
	Examin	er	4a. Facility Name (If not institution, give				wn, or Location o	f Death	4c. County of Dea		
H	Funand		Paradise Assisted  5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Y		24 Hrs. 8. Date of B		thplace (State or Foreign ountry)	
	Funeral Director			_M 215 F	4 Yrs.	Months D	ays Hours	Min. (Month, I	28,1919 New	Jersey	
-	pu ,		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits	
	faryla show	ō	Maryland Baltime		Catonsy					1 ☐ Yes 2 No	
	the h	Director	10e. Street and Number	516	Catons	10f. Zip Co	nde		10g. Citizen of What C	ountry?	
	3a or	Ö	6348 Frederick	Road			21228	U.S.A.	U.S.A.		
9	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or items 23a or 28a-f show event, I're Medical Eracinet must be notified at	/ Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent If Yes, specify		gin? (Specify Yes or N , Puerto Rican, etc.)	14. Race - Am Black, Whi	te, etc.	
00	hours ural',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	160 Door	dont's House O	logunation		16b. Kind of Business	White	
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b	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, Ina M	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Midd	e, Maiden Surname)		
/lar	should be ind Mental I	ToE	Max Zeppelin				Est	tella Rich	ner		
ä	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (7						ber, City or Town, State,		
	Pages 1 and 2 nent of Health ant: If item 27 I ury or other tre		Henry Winters (	Son)				Road Cat	20c. Location - City or	ryland 21228	
Jor	ages nt of h :: If ite		1 ☐ Burial 2 🖺 Cremation 3 ☐	Memovai irom State	b. Place of Dispersion of Disp		1				
Baltimore,	permit. Pages Department of Important: If it any injury or o		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>					3-10-04	Laurel, Man	*	
Ba	permit. Departr Importa any inju		Dancerd	of he brock	William Wil	tzke Fi	uneral H ondson A	Home of Car Avenue Cate	tonsville, I	Inc. aryland 21228	
¥	Physician /Medical Examiner	Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events	a. End Stral Due to (or as a don Due to (or as a con c.	sequence of):	ners De	muntia			Interval Between Onset and Death	
O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1	Due to (or as a cond.  23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	gnancy etal death 3 (	□Ectopic pregr			23d. Date of de Month	livery Day Year	
P.0	that the de led by the a detached f		Part II. Dther significant conditions of	ontributing to death but not	resulting in the u	inderlying caus	se given in Part I.	23e. Dio	tobacco use contribute to	o the cause of death?	
Records,	uires than signed I	d by						1 🗆	Yes 2□No 3□P	robably 4 12 Unknown	
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of	<b>ਦ</b> ≑ ख	on: To B	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year			Other: 4 Nu Injury at Work?		sidence 6 1 Other (Spe how injury occurred	porty) Assisted Living	
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	.		М	1 Yes 2 1				
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	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deal	th occurred at the	he time, date an my opinion, dea	d place, and due to the	e cause(s) and manner a , date and place, and du	s stated. e to the cause(s)	
	o the o the omple	Me	29b. Signature and title of certifier	Stated.		29c. L	icense number		29d. Date signed (Mon	th, Day, Year)	
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<u> </u>	¥		N.S.Rajapakse, MO	25 Main Stre	et-suite	200 - 1	Ceistersto	wan, Maryla	nd 21136		
is.	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 1 1 2	25 Main Stree 32. Registrar's Si	gnature	parti					

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2001 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev 1325 P.4 RoberT Fetrow Harel 1,2004 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) 52 Transverse Road Baltimore Co. Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Dev. Year) August 20 1965 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) Days Months 1₽M 2□F 38 Yrs. 215 80 1490 Baltimore, Maryland Usuel Residence of Decedent 10d. tnside City Limits 10c. City, Town or Location 10e. Stete 10b. County 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 52 Transverse Road 21220 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A Cleaning Person Elaines Cleaning Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Robert Henry Fetrow Sr. Elaine Ann Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Elaine Fetrow (Mother) 940 Thompson Blvd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State Holly Hill Cemetery March 11 2004 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lassahn Funeral Home Inc. 23e. Pert1. Enter the discusse, or complications that damed the death. Do not enter the most of ying, such as carriac or respiratory 21236. Shock, or heart failure. List only one cause on eech line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) by Hanging Surcide Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 257No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1325 P Suicide by Hanging March 7,2004 1 Yes 2 XNo 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Fural- oute Numb 28f. Location (Street and Number or Fural- oute Numb 28f. Location (Street and Number or Fural- oute Numb 28f. Location (Street and Number or Fural- oute Numb 28f. 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within 24 hours efter death.

To the Funerei Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

treumstic event, the Medical Examiner must be notified a

Peges 1 end 2 should be filed within 72 hours after death with in nent of Heelth end Mental Hygiene.

ant: If item 27 ie marked other then "naturel", or items 23e or inny or other treumatic event, the Medical Examiner must be not you other treumatic event, the Medical Examiner must be not perfect the modical Examiner must be not be the fired that th

Depertment of important: If its any injury or o

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

**Funeral Director** 

Completed by

by Physician/Medical Examiner Completed Medical Certification: To Be

27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6 Trimble Hill CT., Luthenville, Maryland 21093 PHILIP MILITELLO. MD.

31. Date filed (Month, Day, Year) 22. Registrar's Signeture

Registrar MAR 1 1 2004

29b. Signature and file of certifier



**DHMH 16 Rev 6/95** 

State

To the

State of Maryland / Department of Health and Mental Hygien 2004 07397 1 - For State Registres Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Marc Soor Marie Helen Fritz /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Havre de Grace Harturd LITIZENS Lure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 XF 82 Yrs. 06/16/1921 Pennsylvania Director 183-12-5504 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Itams 23a or 28a-f show the Mazical Exarciner rust be notified at 1XYes 2 ☐ No Directo MD Harford Havre de Grace 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code USA 21078 100 Revolution Street, Apt. 205 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Medical Secretary U.S. Government permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any nijury or other traumatic avent, the once. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle, Last) Be Catherine Zielinski John J. Gessig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 419, North East, MD 21901 Robert G. Fritz- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) R.A. Ferris & Co. 03/05/04 West Chester, PA 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. | 123 S. Washington, Havre de Grace, MD 21078 Approximate Interval Between Onset and Death 23a Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Homach Immediate Cause (Final disease or condition resulting in death) Physician ar cinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate any leading to immediate any leading to immediate any leading to the solution of the sequence of th Due to (or as a consequence of). Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 1 10 P this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D-15994 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Speaks HAVRE DE GRACE S. ilNION AVE M.D. 31. Date filed (Month, Day, Year) State 2004 BUSE Registrar

Fritz, Marie

State of Maryland / Department of Health and Mental Hygiene 2004 07398 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ·39P **Physician** ARILI MARCH 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2**X**F 81 407 28 5869 Sept. 1922 Kentucky Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylai Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show eny injury or other treumatic event, I'm Medical Exartment must be notified at 1X Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Arsan Avenue 21225 U.S. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aron Hamilton Sis Sawers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denny Allen Son 621 Arsan Avenue Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakeview Cemetery 3/10/2004 Sykesville, Maryland 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Juneral Service 200 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** 30 MINUTE /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) detached o 9 Unknown 9 Unknown ٦ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 212 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. the e 29d. Date signed (Month, Day, Year) 29b. Sign sture and title of certified 29c. License number INTEKNAL DS1104 MEDICINE MARCH X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INGTON AVENUE, 6 ALTI MORE IN A VEMULAKONDA 4710 PENNINGTON AVENUE, 6 ALTI MORE MD, 21226 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 

DHMH 17 Rev 1/2001

Registrar

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Н			Cer	tificate of Death	Reg. No. 2004	07399
	Physic	ian	1. Decedent's Name (First, Middle, Last)		. Dete of Deeth Month / Day Year	3. Time of Death
100	/Medi	cal	RUTH ELIZABETH FOSTER  49 Facility Neme (If not institution, give street and number)	4b. City, Town, or Local	tion of Deeth 4c. County of Death	
J.	Exami	ner	567 GREEN ST.	HAVRE DE	^	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey)	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.		plece (State or Foreign
	Director		373-03-0165 1 M 2 F 88 Yrs.		-eb 21,1916 Mic	CHIGAN
	ylend wow		10a. Stete 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	e Man	ctor	MD HARFORD HAVRE	DE GRACE		1 Yes 2 □ No
	or 28	Director	10e. Street end Number	10f. Zip Code	10g. Citizen of What Cou	untry?
	eeth v		507 GREEN ST.  11. Marital Stetus  12. Was Decedent Ever in U.S.  13. W.	/as Decedent of Hispanic Origin? (Specif	ty Yes or No- 14. Race - Amer	OTATES Indian
0	oftar d	Funeral	1 Never Merried 2 Merried 1 Ves 2 No	Vas Decedent of Hispanic Origin? (Specif Yes, specify Cuben, Mexican, Puerto Ric		, etc.
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pu	be filed tel Hyg d other event,	BeC	17. Fether's Name (First, Middle, Last)		First, Middle, Maiden Sumeme)	
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	laai Haai		ERROL HOCH/NEPHEN 501 (20a. Method of Disposition 20b. Plece of Dispos	GREEN ST. HAVR	E DE GRACE MI Date 20c. Location - City or T	own, State
Baltimore,	e = 5		1   Burial 2   Cremation 3   Hemoval from State	etory or other piece) VIGIFTS REG. 3/	8/04 HANOVER	MD
alti	permit. Pe Departmen Important: any injury			Name end Address of Fecility		,111
<b>a</b>	80 5 5 8	- 13	M. Hahm	Daugherty Family Funeral Home 2601 Mountain Road - F	Pasadena, MD. 21122	
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	Examiner		disease or condition resulting in death)  a. On ges/I v	e Heart Failur		Syears
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	requiras that the death certificate be executed een signed by the attending physicien end hould be datached for use es the buriel-transit	Examiner	Sequentially list conditions, if env. leading to immediate	ence of):		
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P.0	ras that the da signed by the a be datached t				1 □ Yas 2 20 No 3 □ Pro	obably 4 Unknown
Records,	uid be	ed by				Vere autopsy findings
000	2 s L	piet			C	vailable prior to ompletion of cause f death?
œ =	The ate by peg	Completed			1  Yes 2  No 1	☐Yes 2☐No
Vital	<u>;</u> ,	Be	25. Was case referred to medical examiner?	26. Place of Death (C		
o	this aldi	. To	27. Menner of Death 28a. Date of Injury 28b, Time of		5 D Residence 6 □ Other (Speci d. Describe how injury occurred	ify)
ion	Attending ir death. ector: After by the fune	ation	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	,,,	
Division	er des rector	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office 28f.	Location (Street and Number or Rur City or Town, State)	rel Route Number,
	oftal or urs efter rai Dir illed in	Cer				
	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: Atter complataly filled in by tha funer	edical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death of the basis of examination end/or invegend manner stated.  1. Certifying Physician: To the basis of examination end/or invegend manner stated.	occurred at the time, date and place, end estigation, in my opinion, death occurred a	due to the cause(s) and menner as s at the time, date and place, and due f	stated. to the cause(s)
	within 2 To the compla	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	, Day, Year)
			My Jarker, MD	015314	Morch 8,	2004
	/		30. Neme end eddress of person who completed cause of death (Item 23e) (Type, P	1	lo 11 , E	1/ 1 /10
	Sta	te	31. Deterflied (Month, Day, Yeer)  32. Registrar's Signeture	orthern Chosape	are 170 spice, E	IKION,
	Registr		ton 1 1 and A A	all to		

DHMH 16 Ray 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:00aM Emma D. Gaw 2004 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Woodlands Assisted Living Baltimore Middle River
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2√2 F 3634 Director 294 07 95 May 14 1908 PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rat, or iteme 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No MD Director Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1903 Tyler Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other traumatic exercises. Funeral 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Completed by SpecifWhite 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USGovernment Procurement Officer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Anna C. Hirth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D.June Nicolette/daughter 1903 Tyler Road Baltimore MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/04 MorelandMemorial Baltimore MD ' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do per enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bleed Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 🗆 No 3 Probably 4 ∰triknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 No or Attending Physicien: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence & Other (Specify) Aparalle 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation 2 🗌 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-38754 M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALICA INASEEM. 709, EASTERN BLVD, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 07401 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** MARCH 9, GOL D ADFI F 5:30 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth JAN 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☑ F 83 MÄRŸLAND 219-18-1686 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic event, the Mydical Examinar must be notified at BALTIMORE BALTIMORE MD 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 130 SLADE AVE., #320 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene important: If tem 27 is marked other than "natural", or ther any injury or other traumatic event, the Mutical Exempted. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry IIIO TRAVELLI AGENT TRAVEL Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BFTTY ADLER Be **STRAUSS** PHILIP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD GOLD (HUSBAND) 130 SLADE AVE., #320 BALTIMORE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State HAR SINAI 3/11/04 OWINGS MILLS, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune at 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, shock, or heart failure. L e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1€ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM ter cause of death (Item 23a) (Type, Print) 30. Name and address of para-1838 lemes ller 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

DHMH 17 Rev 1/2001

ORIGINAL

				1 - For State Registrar		ryland / Depa		lealth and M	ental Hygiei	-	07402
				Decedent's Name (First, Middle, Last)	1				2. Date of Death		3. Time of Death
		Physici /Medio		Harry A. Gatto					March	9 2004	9:34 A M
	3	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
				Catonsville Com	mons		Catons			Baltimo:	re
		Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
		Director		220-24-5510 Light Residence of Decedent		75 Yrs.			Feb. 16,19	929   Mai	ryland
2		land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
5		Mary 1 sh	ţō	Maryland Baltimo	re	Balti	more				1 ☐ Yes 21⁄2 No
tam		r 28e	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
7		h with	ai D	1034 Circle Dri	ve		2122	7		U.S.A.	
		deat ms	ner		12. Was Decedent E Armed Forces?	ver in U.S. 13.		ispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri Black, White,	
10,	ဖွ	after or the	J.	1 Never Married 2 ☐ Married	11X Yes 2 ☐ N	0	1 □ Yes 21⊠ No		riloari, etc.)	C'6"	
B	903	nours urel',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WW II				WI	nite
2	5-	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28e-1 show ne Madical Examiner must be rodified at	lete	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Deced	dent's Usual Occup- kind of work done o	ation during most of worki d)	ing 16b	. Kind of Business/In	ndustry
V	21215-0036	withi	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5-	+)	f Employe			Jewelry	
•	9	Hyg other	Be C	17. Father's Name (First, Middle, Last)			1 1		(First, Middle, Maid		
	lan	ald be denta rked tic ev	To B	John Gatto				Mary A	lascio		
	ary	and N s ma	Γ	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street	and Number or Rura	Il Route Number, Cit	ty or Town, State, Zip	Code)
	Σ	and 2 salth n 27 I		Nicholas Gatto (	Brother)				Vagas, NV	89031	
	ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	:e) D	Date 20c.	Location - City or To	own, State
	Ë	Pag ment ent:		'4 □Donation 5 □ Other (Specify)		New Cath	edral Cem	etery 3-1	2-2004 Ba	ltimore,	Maryland
	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	9/	( ) 22 W	Name and Address	ss of Facility neral Home	e of Cator	nsville, sville, M	nc <sub>1228</sub>
•		Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to or as a	the death. Do not enter.  Cum  consequence of):		g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last		2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
		that the od by detac		Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
	sp.	luires n sign Ild be	d by	Cerepi	al Va	Scalar	Accid	ent	1 ☐ Yes	2 □No 3 □ Prob	oably 4 2 Unknown
	000	sw requir s been s s should	Completed	Dom	endia				24a. Was an	24b. Were auto	ppsy findings available
	Re	: The law cate has t page 2s	E						autopsy performed 1 ☐ Yes 2 【	? death?	mpletion of cause of
	ita	icien: The certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death		10 100	222.10
	ţ <	Physicien: this certific ral director,	2	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1	nt 2 ER/Outpatien	t 3□ DOA Othe	er: 4 Nursing Hon	ne 5 🗆 Residence	6 ☐ Other (Specif	<b>(y</b> )
,	Division of Vital Records,	inding Physicien: ath. rr: After this certifica te funeral director, p		27. Manner of Death 1    Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work M 1 []		28d. Describe how in	njury occurred	
12	Divis	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, stre . <i>(Specify)</i>	et, factory, office	2	28f. Location (Street City or Town, St.	and Number or Rura ate)	al Route Number,
		ne Hospil 24 hour ne Funer	Medicai	29a. Certifier 1. Certifying Phys (Check only one) 2 ☐ Medical Examin	sicien: To the best oner: On the basis of and manner state	f my knowledge, death examination and/or inv ed.	occurred at the time restigation, in my of	ne, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)
		To the within To the complex c	ž	29b. Signature and title of certifier	0.00	1.	29c. License			Date signed (Month.	Day, Year)
	•	./		I we Attel	uxing p	175020 Bin	US	73642	1	arch (	0200K
		<b>b</b>		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print) avon Bl	'vd 30	3 Balt	mono 2	1239
		Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 200	37 Registra	r's Signature	whe				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2004 07403

		•	For State Registrar	orato or marytana /		rificate of L			Reg. No.	4 01400
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	Edward Hur	len			2. Date of Dea Month March	Day	3. Time of Death Year 004 12:05 M
>	Examin		4a. Facility Name (If not institution, give 3423 Piedmont Ave			4b. City, Town, or Balto	Location of Death	1	4c. County o	Death
	Funeral Director		219-01-9003	X M 2□F 7. Age (In yrs. last)	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	h y, Year) 8-1912	9. Birthplece (State or Foreign Country) Md
	show	ō	Usuel Residence of Decedent  10a. State  10b. County	10c. City, To		ation				10d. Inside City Limits 1 🐧 Yes 2 🔲 No
	the h	rect	Md N/A  10e. Street and Number	Balto	0	10f. Zip Code			10g. Citizen of Wi	nat Country?
	3a or		3423 Piedmont Av	enue		2121	6		USA	ŕ
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If marked other than "natural", or Itema 23e or 28a-f show other traumatic event, the Mcdcal Examiner is ust bus rolling at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates:		das Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No		pecify Yes or No o Rican, etc.)	Black	- American Indian, , White, etc. Black
5-0	72 h	etec	15. Decedent's Ed (Specify only highest grad		(Give k	ent's Usual Occupa	during most of wor	king	16b. Kind of Bus	
121	within ene. than "	Completed	Elementary/Secondary (0·12) 12th grade	College (1-4or 5+) N/A		ONOTuse retired tal Aide	)		Veterans	Administration
d 2	e filed within al Hygiene. other than vent, the Ma		17. Father's Name (First, Middle, Last)	N/A 1	поврт	tal Alue	18. Mother's Nan	ne (First, Middle,	Maiden Sumame	)
an	should be and Mental s marked o umatic eve	To Be	Thomas Hurley				Emma Wa	llace		
N Z	should be nd Mental marked	F	19a. Informant's Name/Relationship (7	ype, Print) 1	9b. Mailing	Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, S	tate, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		Richard E. Hurle  20a. Method of Disposition  1 Durial 2 Cremation 3 Companies  4 Donation 5 Other (Specify	20b. Place ceme	of Dispos etery, crem	3 Piedmon ition (Name of atory or other plac Mem Park	θ)	Date	Md 212 20c. Location - C	City or Town, Stete
Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service Lines			Name and Addres	1	March F	'/H West h Avenue	
¥.			23a. Par 1. Enter the disease, or composhock, or heart failure. List only	olications that caused the death. Done cause on each line.	o not ente	r the mode of dyin	g, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Dehydra	tur	U				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of): ,	\				
	LAdiminet		Sequentially list conditions.	b. VNA NU +V		V				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a consequent	Ja Giy.					
oʻ	tificate be executed ng physician and as the burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a consequent	ce of):					
68760,	ate be hysicia the bu	edical		d						
.O. Box 6	ath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □I	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Day Year
۵.	uires that the de signed by the a d be detached t	by	Part II. Other significent conditions of	ontributing to death but not resulting		derlying cause give	en in Part I.	23e. Did to	¥ .	oute to the cause of death?
Records,	The law requir ate has been si page 2 should	Completed	Hyper	lipidemin					rmed? pri	ere autopsy findings available for to completion of cause of ath?
Vital	en: T tificate tor, pa	CC	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes ath (Check only o	-17	Yes 2 No
>	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3□ DOA Othe			dence 6 Other	(Specify)
on of	ling After fune	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work M 1 🗆			now injury occurred	
Division	al or Attend after death I Director: / d in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	vsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and man date and place, an	ner as stated. id due to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Year)
	. 1		Arthu (	) 1		Do	10473	29	3/8/0	Y
	4		30. Name and address of person who	ompleted cause of death (Item 23	a) (Type, F	Print)	0 7 1	2 2-		
			31. Date (Medy (Month, Day, Year)	32. Registrar's Signature	9 11	7,000		L 20		
	Sta	ite	31. Date (Nedy Month, Day, Year)	Sz. riogistiai s Signature	0 -	e e				

State of Maryland / Department of Health and Mental Hygiene 2004 07404 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:15 PM **Physician** 8,2004 HOFFMan March harles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical System.
7. Age (In yrs. last birthday) BALTIMORE
If Under 1 Year If Under 24 Hrs. Maryland Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Nu **Funeral** Days Hours 1 ☐ M 2 ☐ F 1919 578-22-6414 85 Yrs. Washington, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23s or 28s-1 show event. The Mudical Exercities retried at 1√TYes 2□No Ocean City MD Worcester Director the 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 21842 U.S.A. 14005 Barge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. iled within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. MNCPPC Supervior Grade 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If Item Z7 is marked other any injury or other trainments. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name /First Middle Lasti Be Mamie Estelle Columbus Carl Adolf Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julie Anna Blucher / grandchild 7990 Aladdin Drive Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Rock Creek Cemetery | 03/20/2004 Washington, D.C. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. Duce 9 313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, dr shock, or heart failure. Lis Immediate Cause (Final disease or condition orpnory **Physician** a Atherosclerotic resulting in death) /Medical Examiner perlension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION ED BY MEDICAL EXAMPLES to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav jo in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Tillnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, ed bluods 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 21 No 24a. Was an ardiác page 2 performed? Yes 244 No certificate 1 ☐ Yes Hospital or Attanding Physicien: 26. Place of Death Check on one Be 25. Was case referred to medical examiner? Hospital: 1 ♣Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death 28b. Time of Certification: DRIVER IN MULTI-VEHICLE Division 1 Natural 5 Pending 1 ☐ Yes 2 Mo after death. investigation 3-2-04 2 Accident Noon 281. Location (Street and Number or Rural Route Number, City or Town, State) 29.5, 0 | NTELSCOON NURSERY F-C 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funaral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai thal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Mie. certifier P177 25 MOUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Green St. Konald Nold. 31. Date filed (Month/Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Yeer James Edward Hudson, Jr. March 5\_ 2004 /Medical 3:15 a 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√ M 2 □ F Director 577-46-1934 69 June 6, 1934 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Anne Arundel Laurel Direct 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 332 Ellerton S. 20724 U.S.A. death rai', or items; 12. Was Decedent Ever in U.S. Armed Forces? 1XXVes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Yes, Give Specify 3 Widowed 4 Divorced Specify: White Year or Dates: "natural" Completed The Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) vear Engineer Department of Defense 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill timent of Health and Mental H trant: If Item 27 is marked off riury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Hudson Virginia Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
sny Injury or other tru
once. Marshall Hudson son 2808 Birdseye Lane Bowie, Maryland 20715 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 3/8/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 42 M00770 Laurel, Maryland 313 Talbott Avenue 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic cancer 2 months /Medical Due to (or as a consequence of) Examiner Hepatic failure / metastasis S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 1 month Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Encephalopathy 2 weeks resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Coagulopathy weeks IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Yes 2X No 3 Probably 4 ☐Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNo 1 Yes 1 ☐ Yes 2XXNo Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🍇XNo Hospital: 2 1 X Mpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Attending After 1 XNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide hours after ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ths 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3450 Fort Meade Rd. #109 Laurel, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - State Registrar			Cei	rtificate of	Death		Reg. No	2004	0740	16
			1. Decedent's Name (First, Middle, L	ast)	-		<u> </u>		2. Date of De	aath Da	Vaar	3. Time of Death	n
	Physici /Medic		Ce	cil W.	Himes	Jr	•		March		ny Year 104	548 a	М
The second	Examin		4a. Fecility Name (If not institution, grant 28 Helicopter I				4b. City, Town, o	or Location of De	ath		County of Death		
					e (In yrs. last bi	irthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	-41-	0.0:45	1	
	Funeral Director		214-72-6683  Usual Residence of Decedent	1 <b>3</b> M 2□ F	38	Yrs.	Months Days		Aug. 1	0 , 1	965 Mary	land	ngn
	land bw		10a. State 10b. County		10c. City, Tow	vn or Lo	cation					10d. Inside City Limi	nits
	Mary	tor	MD Balti	more			Middl	e Rive	r			1 🗆 Yes 2 🕽 🕻	No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What Cou	ntry?	
	should be filed within 72 hours after death with the Maryland Adminal Hygene. marked other than "natural", or frems 23a or 28a-f show maric avant, its Mulical Examiner hand by notified at		28 Helicopter	Drive			212	20		US	A		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.1	Was Decedent of I	Hispanic Origin?	(Specify Yes or No	o-	14. Race - Ameri Black, White,		
36	or It		1 Never Married 2 X Married	1 Yes 25	No	+	1 ☐ Yes 2 🕱 No		31.0 1 1.0411, 0.01.)				
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g	il Hyg othe	Bec	17. Father's Name (First, Middle, Las	it)				18. Mother's N	ame (First, Middle	, Maidei	n Surname)		
<u>a</u>	ould be filed wil Mental Hygien Narked other th	To B	Cecil W. Him	es Sr.				Kat	tharyn :	Kale	е		
Maryland 21215-0036	2 6 6 2		19a. Informant's Name/Relationship	(Type, Print)							or Town, State, Zij		
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ore	Pages 1 nent of H int: If ited iry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State	cemete	ary, crer	sition (Name of matory or other pla	/	Date		ocation - City or To		
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Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Lice	insee / /	00.	22	. Name and Addre	_				neofEsse	X
			23a. Pert1. Enter the disease, or cor shock, or heart failure. List one	nolications that caused	the death Do	not ent	er the mode of dyl	Mace Av	re. Balt iac or respiratory a	I I MC	re MD 2	Approximate	
	Physician		Immediate Cause (Final	,								Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. ASPHYX Due to (or as	a consequence	of):							
L	Examiner			HANE-11									
	P =	ner	Sequentially list conditions, tary leading to inchediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of)							
	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.									
20	the death certificate be executed y the attending physician and tched for use as the buriat-transit	I Ex	resulting in death) cast	Due to (or as	a consequence	of):							
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B	atter d for u	ciar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death		Ectopic pregnanc Other (specify)	у		Î	23d. Date of delive Month	Day Year	
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٠ <u>,</u>	res that igned b	by P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?	
ī	w requires that been signed b should be deta	ed k							10	Yes 2	No 3□ Prot	oably 4 DUnknov	wn
Records,	aw as b	piet							24a. Was		24b. Were auto	ppsy findings availab	ble
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Vital	certifica rector, p	Bec	25. Was case referred to medical examiner?						eath (Check only				
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sion of	fter fter iner	ation:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur	v Yeer)	Time of Injury	W <sub>0</sub>	rk?	SV BJECT			6	
3	endi eath. or: A the fu	at	2 Accident investigati	on FOUND 3/9	104 100	55:3	PH.	Yes 2 ZNo	2 0700	/			

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

Division

State Registrar

Certification

Medical

3 Suicide 4 Homicide

(Check only one)

29b. Signature and title of certifier unell

6 Could not be determined

29c. License number OCME

RESIDENCE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28 HELL WATER DR. ESSEX, MI)

March 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21.201

ANA RUBIO 31. Date filed (Month, Day, Year)

MAR 1 1 2004



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

04

PORCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** February Ź8, 2004 Valentine Holewinski 11:31 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3112 Wallford Road #F Dunda1k Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country)
 Unk 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 70 213-32-3648 Director July 4, 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show d other then "natural", or Itema 23s or 28a-f show event, the Modical Exemples rough be notified at MD Baltimore Dunda1k 1 ☐ Yes 2X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Wallford Road #F 21222 USA death unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Mamed 2 Married 1 ☐Yes 2 ☐ No unk Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 12 should be fi h and Mental H 7 Is marked of unk Pages 1 and 2 should nent of Health and Men 2 other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Laurie Welebob/MEO item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1 □ Bunal 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 🗓 Other (Specify) in state in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronal D S . Ware Baltimore, MD Tun Approximate Interval Between Onset and Death √23a. Pa 1. Enter the disease, of complications that caused the death.
k, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** a. Artenioscheroti 10 years resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequenca of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2**X** No 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) who completed cause of death (Item 23a) (Type, Print) Hill CT. Lutherville, Maryland 21093 MILITELLO 6 31. Date filed Month 32. Registrar's Signature State Registrar

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Baltimore, Maryland 21215-0036

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/Medical		IKE NORM		HILL	( )		45 0:5:	T	I continue of D		March	02	. County of	004   1	1:30 P <sup>M</sup>
Examiner	1	4a. Facility Name (If not instit	_	e street and nu	m <i>ber)</i>			nove	Location of D	реант			-	runde	
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or Items 23s		11. Marital Status		Armed F		J.S. 13.	Was Deced If Yes, spec	lent of H rify Cuba	ispanic Origin' In, Mexican, P	? (Spe Puerto	ncity Yes or No Rican, etc.)	0-		- American White, etc.	
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be file tal Hyge d othe event,		17. Father's Name (First, Mic	ddle, Last	)	•				18. Mother's	Name	(First, Middle	, Maider	n Surname,	)	
Ment barked arrice		IKE WINSLOW H	HILL								Y MCKENN				11.20
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and ealth m 27 her tr	-	LINDA COOK			20h I	811 / Place of Dispo			ROAD, GLE		ORNIE, M			ity or Town	State
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permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exact and in the Property of the Completed by To Be Completed by		21. Signature of Funeral Se	40	1 in	#M01148	4			ss of Facility  GHWAY S.					51	
þ.		23a. Part1. Enter the disease shock, or heart failure.	e, or com				ter the mod	e of dyin	ig, such as car	rdiac c	r respiratory a	ırrest,		ln.	pproximate terval Between
Physician		Immediate Cause (Final disease or condition	0.	mu	Otis	Oe.		m						0	nset and Death
/Medical		resulting in death)		Due to	(or as a conse	quence of):	0								
Examiner		Sequentially list conditions,		b											
executed in and ial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to	o (or as a consec	quence of):									
be executed sician and burial-transit	3	that initiated events resulting in death) Last		c	o (or as a conse	guence of):						-			
ocia on		-	ı		,	, .									
physicate the target	3			d											
es that the death certificate be gned by the attending physicic be detached for use as the bu by Physician/Medical		IF FEMALE: 23b. Was decedent pregnat	nt I		utcome of pregn							- 1	23d. Date	of delivery	
death d for	3	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Preg	birth 2 ☐ Feta gnant at time of o		□Ectopic pi □ Other (sp		···				Mont	th Da	ay Year
res that the de signed by the a lbe detached the by Dhystr	2	9 🗆 Unknown		9∐ Unk	nown										
s tha		Part II. Other significant co	nditions	contributing to	death but not re	sulting in the u	underlying o	ause giv	en in Part I.				* *		cause of death?
w require	3										10	Yes 2	2No 3	Probab	ly 4 Unknown
The law require cate has been single 2 should	2									_	24a. Was	POSY	pr	for to comp	findings available letion of cause of
The ate his page	5										1X Yes	ormed? 2 □ No		Yes 2	□ No
cian: ertifici ector,		25. Was case referred to m examiner?	edical							Death	(Check only				
hysic his ce il dire	2	1 XYes 2 □ No				ER/Outpatie			4   Nursi		me 5□Res				at scene
ing P	5	27. Manner of Death 1 □ Natural 5 □ F	ending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injur Wor	k?		28d. Describe Decleu	ed 1	Drives	105	control
tend leath tor: / the f	2		vestigation	ho -	2 -04 ce of Injury - At I		3P,M		Yes 2 No		malling 281 Location			r or Bural B	Route Number A
tal or Attending P is after death. al Director: After t led in by the funera		4  Homicide	etermine	buil	ding, etc. (Spec	roa	d	y, omca			28f. Location City or To	wn, Stat	(e) 447 ) M.D.	4 Rac	A. Co.
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the templated for use as the templated for the physical Certification. To Be Completed by Dhys Frian Machins		29a. Certifier 1 Ce (Check only 2 Me	rtifying P dicel Exe	miner: On the	he best of my kn basis of examin inner stated.	lowledge, dea lation and/or in	th occurred nvestigation	at the ti	me, date and p ppinion, death	place, occurr	and due to the	cause(s	s) and man nd place, ar	ner as state	ed. e cause(s)
o the vithin o the omple	ME	10	erffier	1	11/		29	c. Licens	e number			29d. Da	ate signed	(Month, Da	y, Year)
H ≤ H ŏ		) AC	1 X	WX	1/ V \			0.0	C.M.E.			Marc	h 03,	2004	Į.

State Registrar 31. Date filed (Month, Day, Year) MAR 1 1 2004

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

			1- State Amend Item #19	State of Marylan				Mental Hy	giene	
			Registrar  1. Decedent's Name (First, Middle, Last)		Ce	rtificate of L	<i>Death</i>	2. Date of Dea	3	
и	Physici	an						Month	Day Ye	
No digital	/Medio		Bertha A. Holif 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat	03 th	0.4 2 ( 4c. County of E	004 7:35 A <sup>M</sup>
	Examili	iei	14827 Old Frede			Woodbin				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.			If Under 24 Hrs Hours Min.		h v. Year)	Birthplace (State or Foreign Country)
	Director		215-09-4130	<sup>M 2</sup> ₹○ F 89	Yrs.	Jayo			, 1914 N	1D
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary f aho	to	MD Howard	WOO	dbine					1 ☐ Yes 2 📉 No
	or 28a	Funeral Director	10e. Street and Number		abilic	10f. Zip Code			10g. Citizen of Wha	t Country?
	23s c	aiD	14827 Old Frede:	rick Road		21797			USA	
	tems tems	nuel		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi II Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	- 14. Race - / Black, V	American Indian, Vhite, etc.
36	rs afte	by Fi	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Tyes 2 □ No WW 2 If Yes, Give Year or Dates:		1 ☐ Yes 2√∑ No	Specify:		Specify:	white
5-0036	72 hours after death with the Maryland naturel', or items 23a or 28e-f ahow dissal Examinar must be notified at	ed	15. Decedent's Educ			dent's Usual Occupa			16b. Kind of Busin	
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	turing most of wo l)	rking		,
2121	filed wit Hygiene other than	Con	12		Tech	nical S			U.S.Arm	ıy
Maryland	2 should be filed withir and Mental Hygiene. is markad other than aumatic event, tra Mi	Be	17. Father's Name (First, Middle, Last)					, , ,	Maiden Surname)	
7	should nd Men marka umatic	T <sub>o</sub>	John Tate	na Print)	10b Maili			la Gilbe	ert er, City or Town, Sta	An Tin On dall
Ma	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f ahow other traumatic event, the Medical Examiner must be notified as		19a. Informant's Name/Relationship (Type Cyndy Gilley							
ē,	Heal Heal tem 2		Cindy Cilley/day 20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place	rederic	k Road	Woodbin 20c. Location - City	e, Md. 21797 or Town, State
9	Pages ent of nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sh.Crema	. 03/0	06/2004	Laurel	, Md
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		21. Signature of Funeral Service License			2. Name and Addres	e of Eagliby	+ zko E	inonal II	omog Tra
m	88548		Juphy	allen	5	555 Twi	n Knoll	s Road	. Columb	omes,Inc.
P			23a. Part1, Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not en	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Resp	irato	ry Fail	ure			Onset and Death
36	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence ol):	-				
	3	Į.	Sequentially list conditions,	Due to (or as a consequence)		eart Fa	ilure			
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			dial In	farctio	n		
oʻ	certificate be executed uding physicien and use as the burial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as a conseq	<del>-</del>					
1760,	ite be iysicie ne bui	cai								
89	ntifica ing ph a as th	Med	IF FEMALE:							
Box	death ce e attend ad for use	lan/	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
0	ires that the death certificate signed by the attending phys d be detached for use as the	by Physician/Medi	in the past 12 nonths? 1 □ Yes 21 No 9 □ Unknown	4 Pregnant at time of di 9 Unknown	eath 5L	Other (specify)				
۵	requires that the leen signed by th hould be detache	/ Ph	Part II. Dther significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
rds	quires n sign	d b						1 <b>X</b> (Y	/es 2□No 3□	Probably 4 Unknown
000		Completed						24a. Was	an 24b. Wer	e autopsy findings available
R	The la	E						autop perfor	rmed? deat	to completion of cause of h? Yes 2 No
ita	sien: artifica ctor. I	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	•	
of Vital Records,	hyeic this ce al dire	2	1 □ Yes 2 No		ER/Outpatie		4   Nursing F		dence 6 Other (	Specify)
n o	ling P	ion:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe h	now injury occurred	
Division	death ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome larm st		Yes 2 □ No	28f Location (S	Street and Number o	r Rural Route Number,
οį	after Dire	erti	4 Homicide determined	building, etc. (Specify	y)			City or Tow	m, State)	
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2		29a. Certifier Certifying Phys	sician: To the best of my kno	wiedge, deat	h occurred at the tim	ne, date and place	e, and due to the	cause(s) and manne	r as stated.
	he Ho in 24 he Fu pietel	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my or	oinion, death occi	urred at the time, o	date and place, and	due to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	24	and the second s	29c. License	number		29d. Date signed (M	fonth, Day, Year)
	,?	1	P K Willes			124	-0367		3/5/0	4
	\		30. Name and address of person who co	mpleted cause of death (Item 8827	0 1	Moia 10	no Oku	14 Sui	les Poli	ubin 40 21045
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa		1-140 14 1C	- Free	1 500	RI UIM	~~ (1) ot- /)
	Regist		MAR 1 1 2004	Mary &	100	de				

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 074

			C	Certificate of Death	,	Reg. No.	0 4	01410
			Decedent's Name (First, Middle, Last)		2. Dete of Dee	eth Dey	Year	3. Time of Death
	Physici /Medio		ELIZABETH M. HAMM		MARCH	6 2	2004	12:56 AM
d	Examir		4e Fecility Neme (If not institution, give street and number)	4b. City, Town, or Loc	ation of Deeth	4c. County	of Death	205
2.				ARFORD RD BALTIM	10RE	BAL	1 Im	ace (State or Foreign
п	Funeral		1DM 2MF GO VI	Months Deys Hours Min.	8. Date of Birt (Month, De)		Counti	y) DNID
	Director		Usual Residence of Decedent		OMN, C	1,1912	MAK	
	show	. [	10a. State 10b. County 10c. City, Town of	r Location			10	d. Inside City Limits
	rith the Maryle or 28a-f shor	Director	MD BAUTIMORE ISALT	IMORE				1 Yes 2□No
	filed within 72 hours after death with the Marylend Hygiens. Hygiens 23a or 28a-f show ent, the Madical Examiner must be notified at	F	10e. Street end Number	10f. Zip Code		10g. Citizen of W		y? STNTES
	23e	-Ea	4700 HARFORD KD	12 Was Decedent of Historic Origin? (Spe	city Ves or No.	JNITE	e - America	J M 160
0 _	ter de	Funeral	11. Marital Stetus 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 11. Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	Rican, etc.)		k, White, e	etc.
5-0020	urs af	þ	3 ☐ Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify	WH	HTE
20 0	72 ho	Completed	15. Decedent's Education (Specify only highest grede completed) (G	ecedent's Usual Occupation Give kind of work done during most of working	na	16b. Kind of Bu	siness/Indu	ustry
7 7	ithin it	Per l	Elementary/Secondery (0-12) College (1-4or 5+)	fe. DO NOT use retired)		FOOD	60	RVICE
7 7	led w hygier nt. In	S	17 February Name / First Middle   Lock)	18. Mother's Name	(First Middle			2VICE
aryland	And be hartai	To Be	17. Father's Neme (First, Middle, Lest) CHARLES ENGLEMANN	MARY	BE	RTRA	ND	
o v t Mary	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (Type, Print)  CHARLES HAMMONDS/SON 331	Maifing Address (Street and Number or Rural) AILSA AVE, S	Route Number	nr, City or Town,	Stete, Zip (	21214
re .	s 1 end of Healt Item 2:		20a. Method of Disposition 20b. Place of Disposition	isposition (Name of	Date	20c. Location -		
E 6				MY GIFTS REG. 3/	18/2004	HAND	NER	,rnb
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatury of Fun (1 S Licensee	22. Name and Address of Fecility  Daugherty Family Funeral Hor	no And Cron	nation Center	DA.	
- 111	20E#9		V. M. Hahm	2601 Mountain Road -	Pasadena.	MD. 21122	r.n.	
	1		23a. Pert 1. Enter the issess, or complications that caused the death. Do not shock, or heart failure. List this one cause in each line.	enter the mode of dying, such as cardiac or	r respiratory ar	rest,	1	Approximate Interval Between Onset end Death
	Physician /Medical		Immediate Cause (Final			10		Chisel ella Deall
	Examiner		disease or condition resulting in death)		سادی	disense		
		Jer	Due to (or as a con	isequence of):			1	
	rifficate be axecuted ng physician end s es the buriel-transit	Examiner	Sequentially list conditions,  Due to (or as a con	nsequence of):				
Ö,	oe axa Sian e puriel∹		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury				į.	
68760,	cate b	edicai	that initieted events resulting in death) Lest Due to (or es e con	sequence of):				
		2	d					
Box	death ce a attandii d for use	Cla	Part If. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I	23b. Did t	obacco use con	ntribute to	the ceuse of death?
P.0	Physician: The law requires that the death ce this certificate has been signed by the attandivel director, page 2 should be datached for use	Physician/	Tat II. Otto algimoun conditions contributing to death but not receiving in it.	io unaonymig outlood groot art alt ri			3 Probe	
ŝ	s tha gned be da	ē						
Division of Vital Records,	equire een si ould l	Completed			24a. Was perfo	an autopsy med?	avai	re autopsy findings ilable prior to apletion of cause
ecc	law ras be	pie						leath?
= H	The sate h	S			YEN	as 2ENc	10	lYes 2□No
Vita	clan: Sertific Sector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death				1
of	Physic this cred dir	٦.	(E) res 2E No 1 Inpatient 2 EH/Outpa	attent 3L DOA 4L Notsing Hon		lence 6 10the		mospice
on	ding h. After fune	to to	27. Manner of Death 1 ☑Neturel 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Dey Year) Inju			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
/isi	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office 2	8f. Location (S	Street and Number	er or Rurel	Route Number,
Ö	s afte	Certification:	4 ☐ Homicide building, efc. (Specify)		Ony or row	m, State)		
	To the Hospital or Attending Phywithin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this complately filled in by the funerel	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, did not be to make the composition of the desired forms of the property of	eeth occurred et the time, date end place, a or investigation, in my opinion, death occurre	nd due to the o	ceuse(s) and ma date and place, a	nner as ste and due to	eted. the cause(s)
	vithir To th	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed	(Month, D	lay, Year)
	,		> Dal Im I no	D40854		318	1200	٩
	Ki		30. Name end eddress of person who completed cause of deeth (ftem 23e) (Ty	rpe, Print)	1.1 ` =		2120	(*)
			31. Date filed (Month, Day, Year) 32. Begister's Signature	Paul, M. Da	HWC	OV C C	1120	12
	Sta Registi		MAR 1 1 2004	Grade)				
			MAR L L (19)4 L LEGGE ST. A.					

DHMH 16 Rev 6/95

Susan Jones 04-AKG

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04-1725 AKG		1- For Unpend Item	#2State of M	Aarylar	nd d Dep	artment	ð[ <b>\</b>	Alth and	Mental Hy	/giene	2 N N	. 071.	1 1
	A				Ce	rtiticate	of L	eath	2. Date of D		200		1 1
Physician	n	Decedent's Name (First, Middle, L     Susan Jones	asi/						Month	Day		3. Time of Dea	
/Medica		4a. Facility Name (If not institution, g	ive street and number	r)		4b. City, To	own, or l	ocation of Deal	<u>March</u>		2004 County of De	2:00	Α
Lxamme		North Arundel Ho						Burnie			ne Arı		
G N Funeral		Social Security Number     6.		Age (In yrs. 43	last birthday,	If Under 1		If Under 24 Hrs Hours Min.				irthplace (Stete or Fo	reign
Director		220-72-5263	ILIM ZKIF	43	Yrs.				June 5			irgínia	
fand ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside City Li	imits
Mary Had	tor	Maryland Anne A	rundel		Glen	Burni	6					1 ☐ Yes 2½	₽No
ath with the Marylar 23s or 28s-f show wat be notified at	lrec	10e. Street and Number				10f. Zip Co				10g. Citiz	zen of What (	Country?	
23e	Funeral Director	224 A Poplar A	lvenue			210	061			Uni	ted St	cates	
after deal or Items	nue	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Decedent If Yes, specify	nt of His Cuban	panic Origin? (S , Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 1	14. Race - An Black, Wh	nerican Indian, nite, etc.	
Is aft	Dy L	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√2 If Yes, Give Year or Dates			1 ☐ Yes 2 ☐	No	Specify:			Specify:	White	
Maryland 21215-0036 td 2 should be filled within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Mudical Expression Triant te notified at	Completed by	15. Decedent's	Education		16a. Dece	dent's Usual C	Occupat	ion		16b. Kir	nd of Busines	s/Industry	
215 e	nple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	DO NOT use	retired)	ring most of wo	rking	Fed	deral (	Goverment	
led will her th		12	2		Comm	unicat:		S Analys	-			epartment	
and the first that H H H H H H H H H H H H H H H H H H H	ge	17. Father's Name (First, Middle, Last Thomas Jones, J							me (First, Middle Ruth Ba		,		
Maryland 2121: 12 should be filed within 12 should be filed within 17 lis marked other than 17 lis marked other than 17 lis marked ovent, the Mark	0	19a. Informant's Name/Relationship			19h Maili	na Address (S	Street ar		ural Route Numb			Zin Codel	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after de if Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner To Bo Company of the Europe		Bruce Jones - Hus	1		224		_	Avenue				yland 210	161
or Health of Health of Health of Health or Item 27 is rother tra		20a. Method of Disposition		20b. F	_	osition (Name matory or othe	-		Date			r Town, State	
imor Pages nent of I		1 ☐ Burial 2 【XCremation 3 1 ☐ Donation 5 ☐ Other (Spec		9				ry 3/1	.2/04	Laur	el, Ma	ryland	
Baltimore, permit. Pages 1 a Department of Hes Important: If itsam any injury or othe ance.		21. Signature of uneral Service Lic			2	2. Name and A	Address	of Facility	moreal II				
00 89F#9		aple	10-01	292	7	250 Was	shir	gton Bl	vd. El	kridg	re. Mar	, Inc. yland 210	75
		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	nplications that cause y one cause on each	ed the deat line.	h. Do not en	ter the mode o	of dying,	such as cardia	or respiratory a	rrest,		Approximate Interval Betweer Onset and Deat	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			rythmi	.a						Oliset and Deal	
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outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.										
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8766 ate be hysicia	20		d										
Attending Physician: The law requires that the death certifical actor. After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the fine this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the fine the funeral director.	Me	IF FEMALE:	22a Huga autaam										
Box Bath cert attendin	an l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic pregr				2:	3d. Date of de Month	elivery Day Year	
P.O. hat the de de by the detached detached Dhyelo	132	1 ☐ Yes 2 ☐ No 9 DUnknown	9□ Unknown	at time or d	eau sc	10ther (specia	··y)						
S, P es that es that be deta	7	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying caus	se given	in Part I.	23e. Did 1	obacco us	e contribute	to the cause of death	?
Cords w requires been sign should be	2	Obesity				<del></del>			1 🗆	Yes 2□	No 3□F	robably 4 🗷 Çnkni	own
Record e law requents been has been pe 2 should	200								24a. Was		24b. Were a	utopsy findings avail	able
The ate ha	5								perfo	rmed?	death?		OI
Division of Vital Records, or attending Physician: The law requires the falter death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	מ	25. Was case referred to medical examiner?				_	1		th (Check only o	1			
Of \Physic this call dire	2	1 X Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatier		Other:	4   Nursing H	lome 5 Resi			ecify)	
On Of Oing Phy h. After thi funeral of the Thin the Thin The The Thin The The Thin The The Thin The Thin The Thin The Thin The Thin The Thin The Thin The Thin The Thin The Thin The Thin Thin Thin Thin Thin Thin Thin Thin		1.X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Yeer)	28b. Time o Injury	M 200.	Injury a Work?	ıt ıs 2 □No	28d. Describe	now injury	occurred		
Division C tel or Attending P is after death. el Director: After t ed in by the funera	2	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	njury - At ho	ome, farm, str	- 4			28f. Location (	Street and	Number or F	ural Route Number,	
Div el or , s after od in b		4 Homicide	building, e	tc. (Specif	v)				City or To	wn, State)			
	Medical	29a. Certifier 1☐ Certifying F (Check only one) 1☑ Medicel Exa	Physicien: To the best aminer: On the basis of and manner si	or examina	wledge, death tion and/or in	h occurred at the vestigation, in	the time, my opir	, date and place nion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)	
To the within 2 within 2 comple	Be	29b. Signature and title of certifier				29c. Li	icense r	number		29d. Date	signed (Mon	th, Dey, Year)	_
		> auetz				0.	C.M	.E.		March	19,2	004	
	-	30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)							-
		04 Day 61 4 61 - 4 6				111	Pen	n Stree	t, Balti	more.	, Mary	land 21201	1
State Registrar		31. Date filed (Month, Day, Year) MAR 1 1 2004		trar's Signa	ture	1	1				_		

			1 - For State Registrar	of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygie	ene2004 07412
	Physici		1. Decedent's Name (First, Middle, Last) Evelyn Elizabeth Keys			2. Date of Death Month March	Day Year 9, 2004 7:50 P M
1	/Medic Examin		4a. Facility Name (If not institution, give street and 3015 Florida Avenue	number)	4b. City, Town, or Location of Deat Baltimore		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	9. Birthplace (State or Foreign Country) 1915 Maryland
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	10c. City, Town or Lo Baltimo			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	ier death with the Marylan Items 23a or 28e-f show Left must be coulded at	Director	10e. Street and Number 3015 Florida Avenue		10f. Zip Code 21227	10g	Citizen of What Country? United States
980	72 hours after death with the Maryland natural, or Items 23s or 28e-1 show dical Exam ar must be molfised at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes,	s 2 X No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer l □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race American Indian, Black, White, etc.  Specify: White
1215-0	within 72 ho ene. than "naturi	Completed		e (1-4or 5+) (Give life. L	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	b. Kind of Business/Industry
Maryland 21215-0036	be filed ital Hygi od other event, I	To Be Co	12 0  17. Father's Name (First, Middle, Last)  Howard Wiggington	Bus 1		me (First, Middle, Me Cannoles	School iden Sumame)
	12 sho h and 7 is m treum		19a. Informant's Name/Relationship (Type, Print) Richard Keys – son	4-	ng Address (Street and Number or Ru egina Drive, Balt		
Baltimore,	o to L		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal fro '4 □ Donation 5 □ Other (Specify)	Meadowride	sition (Name of natory or other place)  pe Cemetery Marc		c. Location - City or Town, State Elkridge, Maryland
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	<u> </u>	107 Wilkens Avenu	e, Baltimo	neral Home, Inc. ore, Maryland 21229
	Enysician /Medical		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of transdisease or condition resulting in death)	at caused the death. Do not entended in each line.	er the mode of dying, such as cardiac	or respiratory arrest	Onset and Death
8760,	Examiner and size of the provided and purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):  to (or as a consequence of):  to (or as a consequence of):			
Р.О. Вох 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to	o death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 100 3   Probably 4   Unknown
Vital Records,		Completed				24a. Was an autopsy performed	
o	this al dir	ation: To Be	27. Manner of Death 28a. Da	□ Inpatient 2 □ ER/Outpatien  ate of Injury fonth, Day Year)  28b. Time of Injury	Other	ome 5 XP sidenc 28d. scribe how	e 6 Other (Specify) injury occurred
Division	e Hospital or Attend 24 hours after death 5 Funeral Director: etely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Pla bu	ace of Injury - At home, farm, stre ilding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, late)
>	To the Höspital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Chack only 2 Medical Examiner: On the	the best of my knowledge, death e basis of examination and/or inv anner stated.	occurred at the time, date and place restigation, in my opinion, death occurred.	rred at the time, date	and place, and due to the cause(s)
	To Toon	Σ	29b. Signature and title of contilier	M	29c. License number		Date signed (Month, Day, Year) Novely, 11, 2004 Bloy Bune, M
	5		30. Name and address of person who completed co	2MD 7845	Danuel of	with 201	Blon Bune, Ad
	Sta Registr		31. Date filed (Month, Day 121) 1 1 2004	. Registrate Signature	A SOUR		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year Catherine Kniaht 2004 11:45 PM March 05 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Severna Park Anne Arundel Genesis Elder Care If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Days 1 □ M 2 🖾 E 216-48-8178 Yrs 08 MD Aug. Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Linthicum 1 ☐ Yes 2 ☐YNo Maryland Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21090 USA 223 Corret Drive 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify. White Specify 3 XWidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Household 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Eva Unknown Clark Bernard 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3491 Marble Arch Drive, Pasadena, MD 21122 (son) Kenneth R. Knight Date 09 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2004 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service License 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CLI Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner man be notified at

Baltimore, Maryland 21215-0036

Examiner ettending physician and for use as the bunal-trensit Physician/Medical Completed by certificate hes birector, page 2 s Be Certification: To

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the funeral director, After this within 24 hours efter det To the Funeral Director completely filled in by th

U		1 Y38 2 No 1 Yes 2 No				
25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)				
1 Yes 2∏ Mo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ursing Home	lome 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner   Death  1   Description   5   Pending investigation	(Month, Dey Year) Injury Work?  Injury Work?  I □ Yes 2 □ No	Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could no determin	28e. Plece of Injury - At home, farm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date end plece, end of caminer: On the basis of examination end/or investigation, in my opinion, death occurred at and manner stated.	lue to the ceuse(s) and manner as steted. the time, date and place, and due to the cause(s)				

State

edicai

29b. Signati

end title of certifie

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Lenni Fer Riedinger MD 8601 Ve

Eteransthy M. Versy lle 32 Registrer's Signature

Registrar

			1 - For Amend Item 18	State of Maryland per Fh, G831, 05/2	d / Depa <b>0/0⁄eb</b>	artment of H	lealth and M Death		ene 9. No. 2 A A L	071.11.
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last</i> Beatrice E	_	kos			2. Date of Death Month March	Day Year 09 2004	3. Time of Death
9	Exami		4a. Facility Name (If not institution, give 159 [ake Shore Dr				Location of Death	, 1101 011	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Se 220-07-0094				If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 14	Year) 9. Birtl	nplace (State or Foreign intry)
	e Maryland Ba-f show	Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne A		, Town or Lo	Pasa	dena			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	23a or 2		159 Lake Shore Dr	i ve		10f. Zip Code	21122	10	g. Citizen of What Co USA	untry?
036	within 72 hours after death with the Maryland ilene. r than "natural", or items 23a or 28a-f show tha Modical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ <b>X</b> No	Ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	within ane. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	tent's Usual Occupa kind of work done of DO NOT use retired HOMEMAKE)	during most of work )	ing 10	6b. Kind of Business/I	
yland 2	be filed ital Hyg od othe evant.	To Be Co	17. Father's Name (First, Middle, Last)	Johnson			18. Mother's Name	noska	aiden Sumame) Besoska	
	1 and 2 s Health ar em 27 ls ther trau		19a. Informant's Name/Relationship (Ty Katherine Krokos 20a. Method of Disposition	(daughter)	609 ace of Dispo	Greenway	SE, Glen	Burnie,	City or Town, State, Z MD 21061 Oc. Location - City or T	
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 XBugial 2 Cremation 3 F '4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License	removal from State	iden Pa	ark Cemet Name and Addres 1111 Mount	ery 200	13 14 <u>B</u> Stalling	altimore.	Maryland Home, P.A.
	Physician /Medical		23a. Pan1. Enter the disease, or compl shopk, or heart failure. List only or Immediate Cause (Fina disease or condition resulting in death)	icatio that caused the eath ne calls on each line.  Leukemia		er the mode of dying	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death WEEKS
58760,	crate be executed physician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du						
P.O. Box 68	death certif e attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
Records, P		by	Part II. Other significant conditions cor Congestive heart		ting in the un	iderlying cause give	n in Part I.		cco use contribute to l	
al Reco	The lar ate has page 2	Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
of Vital	d is	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	lospital: 1  ☐ Inpatient 2  ☐ E	R/Outpatient	3 DOA Othe	26. Place of Death  r: 4 □ Nursing Hor		ce 6 □Other (Speci	(y)
Division o	Attending Ph ir death. ector: After th by the funeral	Certification:	27. Manner of Death  1 \( \overline{\text{ZNAtural}} \) 2 \( \overline{\text{Accident}} \) 3 \( \overline{\text{Suicide}} \) 6 \( \overline{\text{Could not be}} \)	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at 2 ? 'es 2 □ No	28d. Describe how	injury occurred	
Divi	i Dirte	Certific	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Town, S	ŕ	
	the Hospital nin 24 hours a the Funeral I npletely filled	edical	one)	sician: To the best of my know her: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due t	tated. o the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	M	1.	29c. License D50	number 1725		Date signed (Month, March 11,	
	8		30. Name and address of person who co Jennifer Riedinger	8601 vetera	ns Hwy		sville A			
	Sta		31. Date filed (Mgr/AR Pay Year) 2004		re	A.				

State of Maryland / Department of Health and Mental Hygiene 2001Certificate of Death 2. Data of Death
Month Day Year
February 28 2004 1. Decedent's Nama (First, Middle, Last) Physician 335PM mildred /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death / 4c County of Death Examiner Kesville ('arrol If Uhdar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Hours Min. Jan 22, 1912 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 19 113-09-2041 92 Director New York Usual Residence of Decedent Peges 1 end 2 should be filled within 72 hours efter deeth with the Meryland nant of Heelth and Mental Hygiene.

Int: if Item 27 is marked other than "nature!", or Itema 23a or 28e-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 710 Obrecht Road 21784 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 14. Race - Amarican Indian. Black, Whita, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) secretary board of education NYC 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) å Jack Klevansky ဥ Anna Baradinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Karp/daughter 754 Central Avenue Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata permit. Peges Depertment of Important: if It eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronal N S. Wade, 22. Nama and Addrass of Facility otor State Anatomy Board 655 W. Baltimora Street Baltimore, MD 21201 Purt1. Enter the disease, or a molecular is fulf caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical ear Examiner Due to (or as a consequence of) Examiner Attending Physician: The lew requires that the deeth certificate be exacuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by the funeral director, page 2 should be detached 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? ovasular accident 1 Tes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: All Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2121No 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending s efter deeth.
I Director: Afted in by the fur 1 Yes 2 No 2 Accident investigation 6 ☐ Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO059943 2004 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abel, Suite 307 C. M.0 295 westminster, MO 21157 Ave.

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

MAR 1 1 2004

22. Registrar's Signature

		1 - For State Registrar	State of M	C	ertificate	f Health and M of Death	Reg.		074
hysici	an	1. Decedent's Name (First, Mide	le, Last)				Date of Death     Month	Day Year	3. Time of Dea
/Medic		GERTRUDE	KING				March	7, 200	
xamir	ıer	4a. Facility Name (If not instituti	11 60	100	4b. City, Tow	n, or Location of Death	, ,	4c. County of Deat	h
		Sinal Hospi  5. Social Security Number		a Himore ge (In yrs. last birthdi		more (11	O Date of Birth	0.01	h-1 /Ct-t F
neral ector		,	1 M 2√X F	ge (iii yrs. iasi biriiida 70 Yrs	Months Da		8. Date of Birth (Month, Day, Ye 4/1/1933		hplace (State or Fountry)
COLOI		248-72-3563 Usual Residence of Decedent					47 17 1333	dLoi	RGETOWN, SC
MOL TH		10a. State 10b. Count	1	10c. City, Town or	Location				10d. Inside City L
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	tor	MARYLAND		BALTIMO	RE				1 □ Yes X2X
a or 28a-f show	Funeral Director	10e. Street and Number			10f. Zip Coo	de	10g.	Citizen of What Co	ountry?
23a	a	6718 CHISHOLM DRI	/E		212	07		U.S.A.	
ems EEE	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 1	3. Was Decedent If Yes, specify (	of Hispanic Origin? (Spe Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
b a		1 Never Married 2 Ma	ried 1 □ Yes 💢 🔯	No	1 □ Yes 2 <b>X</b> X		, , , , ,	Specify: BLA	
E H	d by	3XXWidowed 4 □ Divorce	Year or Dates:						
"nat	Completed	15. Decede (Specify only high	nt's Education est grade completed)	/G	cedent's Usual Ocive kind of work do	one during most of working	g 16b	. Kind of Business/	Industry
the Maria	ш	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use re AUNDRESS	urea)		1 Alluppy	
nt, II	ပိ	12 17. Father's Name (First, Middle	Last)		AUNDRESS	18. Mother's Name	(First Middle Maid	LAUNDRY	
ad other	Be	HERMAN CAMPBELL				ANNIE N		ion comanio,	
markad other the imatic event, the	J.	19a. Informant's Name/Relation	shin (Tyne Print)	19h M:	ailing Address (Str	reet and Number or Rural		hy or Town State	Zin Code)
s 2		HORACE MITCHELL	3 mp (1) po, 1 mm)						ap code)
item 27 Is marks r other traumatic		20a. Method of Disposition		20b. Place of Dis	sposition (Name of	Y ROAD, BALTIMO		ND 21207 Location - City or	Town, State
:: = ::   o = :		1 XXBurial 2 ☐ Cremation		,	crematory or other	1	7.71		
Important: If ite any injury or otl once.		`4 □ Donation 5 □ Other (		MORNING	GLORY CEME	TERY 3/13/2 Idress of Facility F11		ORGETOWN CO	UNTY, SC
any ir		KELLY GREGORY	U E	111/0		HIGHWAY S., GI			
		23a. Part 1. Enter the disease, shock, of heart failure. Lis	1	01148				MD 21061	Approximate
dical purial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Acu Due to (or as b Due to (or as	^	1 /				Interval Betwe Onset and De 11 - day 0
by the attending physician tached for use as the buria	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	e of pregnancy 2 Fetal death	3 □Ectopic pregna 5 □ Other (specify			23d. Date of del Month	ivery Day Yea
9 <b>9</b>	y Ph	Part II. Other significant condi	ons contributing to death t	but not resulting in the	e underlying cause	given in Part I.	23e. Did tobacc	o use contribute lo	the cause of dea
n sign ald bla	q p	Diabetes Mi	Mitus Non-	-insulin de	ependent	<del>-</del>	1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Donk
should should	Completed by	Atherosclero	•				24a. Was an	24b. Were au	topsy findings ava
page 2	шс	7	C /10 411 /	D. 3C 3C			autopsy performed	prior to death?	completion of caus
certificat rector, p		25. Was case referred to medic	al .			26. Place of Death	(Check only one)	No 1 ☐ Yes	2 1 No
	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ER/Outpa	tient 3 DOA	Other: 4 Nursing Hom		6 ∏Other (Spec	rifu)
		27. Manner of Death	28a. Date of Inju		e of 28c. I		8d. Describe how in		,y)
= =	atlo	1 Matural 5 Pend 2 Accident inves	igation	a <i>y Year)</i> Injur		1 ☐ Yes 2 ☐ No			
After th funeral		3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide deter	nined   286. Place of In	jury - At home, farm, tc. (Specify)	street, factory, offi	ice 2	Bf. Location (Street City or Town, St		iral Route Number
After th funeral	Certific			4 - 1 - 1 - 1		e time, date and place, a	nd due to the cause	(s) and manner as	stated.
After th funeral	dical Certification:	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or	eath occurred at th r investigation, in п	ny opinion, death occurre	d at the time, date a	and place, and due	to the cause(s)
After th funeral	Medical Certiflo	(Check only 2   Medica one)  29b. Signature and title of certif	Examiner: On the basis of and manner start and manner sta	of examination and/or	r investigation, in n	ny opinion, death occurre ense number	d at the time, date a	Date signed (Month	n, Day, Year)
= =		(Check only 2   Medica one)  29b. Signature and title of certif	Examiner: On the basis of and manner start and manner sta	of examination and/or	r investigation, in n	ny opinion, death occurre ense number	d at the time, date a	Date signed (Month	n, Day, Year)
After th funeral		(Check only 2   Medica one)  29b. Signature and title of certif	er  Who completed cause of	of examination and/oi	r investigation, in n	ny opinion, death occurre	d at the time, date a	Date signed (Month	n, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

07417 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** JOHN 03 1: COA.M 08 KOWAL 04 /Medical 4a Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Randallstown Randallstown Baltimore If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. Birthplace (State or Foraign Country) 8. Data of Birth (Month, Day, Yaar) March 13 1915 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax **Funeral** 1 M 2 □ F Days Months 217 09 3370 Director Hopewell, Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene.

Int: If Item 27 is marked other than "naturel", or items 23s or 28s-1 show ury or other traumatic event, the Medical Exeminer must be notified at 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No **Funeral Director** Maryland Baltimore City Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6305 Mbyer Avenue 21206 USA 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U.S. Armad Forcas? 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. 1 Mas 2 No If Yas, Giva Yaar or Datas: W II 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Carpenter Formen Bethlehem Steel 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Theodore Kowal Ann Unknown 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Coda) Tadea Kowal 6305 Mover Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If any Injury or pace. Metro Crematory Inc. March 9 2004 Baltimore, Maryland 22. Name and Addrass of Facility
Lassahn Funeral Home Inc 21. Signatura of Funeral Sarvice Licensaa 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batwaan Onsat and Daath **Physician** Immediate Ceusa (Final disaasa or condition rasulting in daath) /Medical monetis DEMENTIA Examiner Dua to (or as a consequence of) Physician/Medical Examiner monons or Attending Physician: The law requires that the death certificate be executed effor death. Sequantially list conditions, if any, leading to immediate ceusa. Enter Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consaquence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? To the Hospital or Attending respective within 24 hours effer death.

To the Funeral Director: After this certificate I 1 Yes 2 ≥ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Wursing Homa 5 Residence - 6 Othar (Spacify) Medical Certification: To 1 Yes 2 No 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 5 Panding invastigation Injury 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba 3 ☐ Suicida Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifier Lecrifying Physician: To tha best of my knowladga, daath occurred at the time, data end place, and dua to the causa(s) and manner as statad.

| Continued in the causa in the time in the causa in the time, data and place, and due to the causa in the cau (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifiar 29c. License number 00053150 MARCH SON 2004 Spephe MD 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) 201-109 BACLIRIVER NECLAD GUPTA SUQUENNYA 3 Registrar's Signatura 31. Date filed (Month, Day, Year) State Deser. MAR 1 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Kahl **Physician** Catherine 2004 03 07 2:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis - Perring Parkway Baltimore Baltimore if Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Deys Months Hours 1□ M 2X) F Director 85 4/07/1918 220-34-6528 Maryland Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mentel Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 💢 No **Funeral Director** MD Baltimore Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9116 Cowenton Avenue 21128 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 21 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Regester's Florist Flower Arranger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Edward Kahl Theresia Noppenberger 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 3807 Perry Hall Road - Perry Hall, MD 21128 Florence Barlow (sister) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 03/10/04 Depertment of Important: If any Injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) Joseph Church Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21087 11750 Belair Road - Kingsville, MD 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Bella Due to (or as e consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown Š ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy funeral director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 1 L Yes 2 LTNU 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Sursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours efter death. To the Funeral Director: After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a, Certifier 19 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entaw of forte 308 Rult. MD 21211 SHOALIZ A HASHON 1 821 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

**DHMH 16 Rev 6/9**5

State Registrar

			1 - For State Registrar	State of Ma	ryland /	Depa	artment of I tificate of	Health ar	nd Mental Hy	giene 20	04 07419			
	Physici /Medi		Decedent's Name (First, Middle, Last)     Donald Norris						2. Date of De Month March	ath Day	Yeer 3. Time of Death 1:30 P M			
F	Examir		4a. Facility Name (If not institution, give s 704 Old Fallstor	street and number)			4b. City, Town, o			4c. County of				
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year Nonths Days				If Under 24	Hrs. 8. Date of Bin Min. (Month, Da May 10,	th y, Year)	Birthplace (State or Foreign Country)     Maryland				
	Maryland a-f ahow iiled at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Harford Fallston								10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	h with the 23a or 28	Dire	10e. Street and Number 704 Old Fallstor	n Road			10f. Zip Code 2104	.7		10g. Citizen of What Count USA				
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f ahow event, the Medical Examinat must be notified at	by Funerai		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:					n? (Specify Yes or No Puerto Rican, etc.)		- American Indian, , White, etc.			
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	+)	(Give i	ent's Usual Occup kind of work done OO NOT use retire	f working	16b. Kind of Bus	iness/Industry				
Maryland 2	ed its &	To Be Co	17. Father's Name (First, Middle, Last) Edward Hall Kelly				/Operat	18. Mother's	Name (First, Middle. ian Marie	Maiden Sumame	chanic Shop			
	s 1 and 2 should of Health and Men Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) Nathalie Kelly /			704	Old Fall	and Number of ston Ro	or Rural Route Number Dad, Falls	r, City or Town, S				
Baltimore,	nit. Pages 1 artment of He ortant: If Itar injury or oth		20a. Method of Disposition  1 □ \$\frac{1}{2}\text{urial} 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		Little Falls Friends 3-9-					Fallsto	n, Maryland			
a B	Departing Depart		21. Signatur uneral Service License	col		I A	binadon.	Marvla	Home, P.A and 21009					
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a	1 8	223	ure A	y dra	cephalu	rest,	Approximate Interval Between Onset and Death			
8/60,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
D	that the death certificate ed by the attending phys detached for use as the	hysician/Med	4 Pregnant at time of death 5 Other (specify)								d. Date of delivery Month Day Year			
ecords, r	w requires that s been signed b should be det	by P	Part II. Other significant conditions conf	zular	not resulting	in the un	derlying cause giv	en in Part I.			ute to the cause of death?			
ב	The la ate has page 2	Completed	Dementia						24a. Was a autops perform	med? prid	ore autopsy findings available or to completion of cause of atth?  J Yes 2 \sum No			
VICA	yaictan: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 □ EB/C	utnationt	3C DOA Othe		Death (Check only or					
JIVISION OF	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	atlon: T	27. Manner of Death 1	28a. Date of Injury (Month, Day	28b.	Time of Injury	28c. Injun Worl			ow injury occurred				
200	ital or Attures after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or Town	n, State)	or Rural Route Number,			
	the Hosp hin 24 hou the Funel npletely fil	Medicai	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of er: On the basis of e and manner state	xamination a	ge, death nd/or inve	istigation, in my op	oinion, death o	ace, and due to the cocurred at the time, d	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)			
	vitl Cor		29b. Signature and title of certifier	2				5 0 /	2 2	9d. Date signed (1) March	Month, Day, Year)			
	10			INCH M.	٠ هـ	(Type, P	vortz	Ave.	BelAir	, Md	2/014			
	Star Registra		31. Date filed (Month, Day, Year) MAR 1 1 2004	82. Registrar	s Signature	6								

		For State Registrar	State of M	aryland /	Departm Certific			nd Menta	l Hygier	20	04 0742
Physici /Medic Examir	al	Decedent's Name (First, Middle, Las BARBA     4a. Facility Name (If not institution, give 3915 Inner Circ	RA street and number)	Ε.	L /N 4b. (		r Location of	MA	RCH		aar 3. Time of Death
Funeral Director		5. Sociaf Security Number 220 28 1234 6. Se		ge (in yrs. iast t	yrs. If U	der 1 Year	If Under 24 Hours	Min. 8. Dat Min. Feb	e of Birth onth, Day, Yea 22,		Birthplace (State or Foreign Country) Maryland
Maryland 8-f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         N/A			wn or Location						10d. Inside City Limits 1XX Yes 2 ☐ No
with the	I Director	10e. Street and Number 3915 Inner Circ	Le		10f	Zip Code 2122	25		10g. (	Citizen of Wha	t Country?
vithin 72 hours after death with the Maryland within 72 hours after death with the Maryland and. than 'naturel', or Itema 23e or 28e-f ehow he Maricel Examilier mast be notified at	d by Funeral	11. Marital Status  1 Never Married ZK Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates:	No	1 □ Y€	s 2 No	Specify:	n? (Specify Ye Puerto Rican,		Black, \ Specify:	
Wat yielid Z I Z I 3-0050 d 2 should be filed within 72 hours aft th and Mental Hygiene. I? Ie marked other than "natural", or treumetic event, the Medical Extra	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12) 11th				f work done T use retired	during most of	of working	16b.	Own H	
should be filed and Mental Hygist marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) Harold						s Name (First, Edith E	Bieden		
		19a. Informant's Name/Relationship (7) Vicky Schertle			9b. Mailing Add 84 Chur						<sup>ite, Zip Code)</sup> 1732' nnsylvania
0 8°= 6		20a. Method of Disposition 1 🗷 Burial 2 Cremation 3		ceme	of Disposition tery, crematory Hill	or other place		Date /9/2004			y or Town, Slate , Maryland
permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Licen		h	22. Nam	e and Addre		Gonce	Funera	1 Serv	rice, P.A. Maryland 2122
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law required by the attending physicien and are page 2 should be detached for use as the burial-transit	lical Examiner	23a. Part 1. Enter the disease or compshock, or heart failure. List only is immediate Cause (Final disease or condition resulting in death)  Security in anothers of any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as	s a consequence	ce of):	<i>k</i>		<b>V</b> 9	Ca	ncen	friterval Between Onset and Death
that the death certifical countries that the death certifical detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		of pregnancy 2 Fetal dea at time of death		nic pregnancy r (specify) _	у			23d. Date of Month	
COLGS, F. w requires that the second should be detailed by the second se	ρ	Part II. Other significant conditions c	ontributing to death	but not resulting	g in the underly	ing cause giv	ven in Part I.	23	Se. Did tobacc		ite to the cause of death?  Probably 4 Unknown
The law requires t ate has been signe page 2 should be o	Completed								la. Was an autopsy performed ☐ Yes 2	? prio	re autopsy findings available to completion of cause of th? Yes 2 \( \) No
Or VICAL Physiclan: Tribis certifical ral director, p.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospitaf: 1 ☐ Inpat	ient 2□ER/	Outpatient 3[	DOA Ott	205	of Death (Chessing Home 5	Residence	6 ☐Other	(Specify)
		27. Magner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 28t	o. Time of Injury	28c. Inju	ry at	28d. <b>D</b>	escribe how in	njury occurred	
DIVISION  al or Attending s after death. In Director: After id in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of If	njury - At home, Ic. (Specify)	, farm, street, fa	ctory, office			cation (Street ty or Town, St		or Rural Route Number,
Hospita 24 hours Funera	Medical C		ysician: To the bes niner: On the basis and manner s	of examination							er as stated. I due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	~ N	1	JU.	29c. Licens	se number	904	29d.	Date signed (I	Month, Day, Year)
4		30. Name and address of person who	completed cause of	death (Item 23	a) (Type, Print)	31	00/30	Sitt	son.	over	Street 21225
St Regist	ate	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature	Anous	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Luedtke Louis /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5 Bunns 1 or to Anna Arund 20 If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 X M 2 ☐ F July Yrs. 220-24-1184 75 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Madical Examiner must be notified at Glen Burnie 1 Yes 2 No Maryland Anne Arundel Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 414 Irene Drive 21061 USA or items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) Selector Warehouse 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny july or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luedtke Katherine Henkel Julius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis W. Luedtke (son) 7867 Pepperbox Lane, Pasaden<u>a, MD 21122</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marchate 12 1 XBurial 2 Cremation 3 Removal from Sta 2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 21. Signature / Funeral Service Stallings Funeral Home, P.A. 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) nermonia **Physician** /Medical Due to (or as a consequence of) **Examiner** fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Examiner physician and the burial transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Tes 21X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

or Attending death. hours after death within 24 hours aft To the Funeral Di completely filled in

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

748006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 BOHIT 2 Registrar's Signature

Registrar

			Please	Type or Prin State of Ma				Ensure All alth and Me	-	ene	
		_	State Registrar		(	Certific	ate of D		Reg	<sub>I-No.</sub> 200	3. Time of Death
V	Physicia	ลัก	<ol> <li>Decedent's Name (First, Middle, Las Patsy Emilie La</li> </ol>						Month	Day Year $3$ 200	
	/Medic Examin	er	4a. Facility Name (If not institution, give PEN/INSU/a Register)		al Mark		City, Town, or Lo	ocation of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 216-38-9735		e (In yrs. last birth	day) If U	nder 1 Year	f Under 24 Hrs. Is	B. Date of Birth (Month, Day, 1) Oec 2, 1	940 9. Bi	nthplace (State or Foreign ountry) ryland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Wicom	Lco	10c. City, Town	or Location sbury					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the a or 28a	Direc	10e. Street and Number 515 Park Avenue			101	. Zip Code	21801	100	Citizen of What C	
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show than Moleal Examirer must be mallified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent   Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			ecedent of Hisp specify Cuban,	panic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Wh Specify: W	erican Indian, ite, elc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items any injury or other traumatic event, the Modest Examire in once.	ompleted	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary 40-12)	ucation de completed) College 11-4or 5		Give kind o ife. DO NO	Usual Occupation of work done durage (1) Use retired)  IS tress	on ring most of working	16	sewing	factory
Maryland 2	uld be filed Mental Hygi srked other stic event,	To Be Co	17. Father's Name (First, Middle, Last) George Leroy Moor	re				8. Mother's Name (	ncock		
Man	d 2 sho th and ! I is ma trauma		19a. Informant's Name/Relationship (7) Robert Lackey/spo					d Number or Rural e Salisbu		City or Town, State,	Zip Code)
Baltimore,	Pages 1 an ent of Heal nt: If Item 2 ry or other		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify	Removal from State	20b. Place of 0	Disposition		Da		Oc. Location - City o	r Town, State
Balti	permit. Departm Importations injury		21. Signatur Funeral Strice Licen Ronal d S		ector		and Address Anator		655 W. I	Baltimore	Street
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	10. 0 10 1	et enter the	mode of dying,		respiratory arres	it,	Approximate Interval Between Onset and Death
1	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of						•
760,	e be executed rsician and e burial-transit	cal Examiner	cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of	):					
P.O. Box 687	that the death certificate to the by the attending physic detached for use as the to the the the the the the the the the the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N							alivery Day Year
	es on pe	ρ	Part II. Other significant conditions of	-		the underly	ing cause given	in Part I.			to the cause of death?  Probably 4 □Unknown
Vital Records,	The law ate has b page 2 st	Completed							24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	nation) 3	DOA Other	26. Place of Death		) ice 6 ⊡Other (Sp	ecifu)
ion of	Sing After fune	Certification: To	27. Manner ol Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da			28c. injury a Work?		3d. Describe how		oony)
Division	after de Directo	ertific	3 Suicide 6 Could not be determined	288. Place of Inj	ury - At home, lari c. (Specify)	n, street, fa	ictory, office	2	Bl. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		ysician: To the best niner: On the basis o and manner st	f examination and						
	To the within To the	Me	29b. Signature and title of certifier				29c. License			d. Date signed (Mor	nth, Day, Year)
			30. Name and address of person who	completed cause of c	death (ttem 23a) (1	ype, Print)	D383				
	Sta	ate.	30. Name and address of person who Renee Desmaris 31. Date liled (Month, Day, Year) MAR 1 1 201	Eastern 32@Registr	ar's Signature	SAI	shury	, mai		*****	
	Regist		MAR 1 1 200	14 Between	a die	frank	1				

DHMH 17 Rev 1/2001

Palsy E. LACKEY 216-38-9735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07423 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 08:15 CROME 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner HOPKINS MORE Johns If Under 1 It Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday, Birthplece (State or Foreign Country) **Funeral** Days Min. 217-68-4492 Usuat Residence of Decedent 1 M 2 □ F Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Director N Yes 2 No MARVLAND 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 0 Ž 1 ☐ Yes 2K No 3 ☐ Widowed 4 N Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be HERBERT JUNIOR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deportment of Health a Important: If Item 27 is any njury or other trac (MOTHER) ANNIE MURICK 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1/3 Burial 2 Cremation 3 Removal from State ZION CEMETERY 4 □ Donation S ☐ Other (Specify) 22. Name and Address of facility 21. Signature 7 Fun val Service License JR. FUNERAL HOME BALTO, MD. 2121 -ULTON AYE. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 16 days /Medical ue to (or as a consequence of): Examiner ERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due o (or as a consequence ot) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 2 No 1 Yes 2□ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Inpatient 2 ER/Outpatient Other: Medical Certification: To 1 Tyes Þ 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 E Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 □ Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the C 29b. Signature and title of certifier 29c. License number 30. Name and address of person who are sted cause of death (Item 23a) (Type, Print) WOIFE 600 N. 31. Date filed (Month Ca 32 Aegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 07424 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0600 /Medical Facility Name (If not institution, give street and number Examiner 4c. County of Death 1021 ester 119 tr TOWN If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Min. Hours 1 ☐ M 2 💢 F 216-48-8745 81 Director Yrs. 1922 England Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 is marked other than "natural; or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at Md. Queen Annes Co. Director Marydel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Duhamel Corner Road 21649 **England** Be Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Own Home 12 Homemaker treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hodges Eliza Roulliet 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) criment of Health a criant: if item 27 is injury or other tree Anne P. Koch 803 Huhamel Corner Road, Marydel, Md. 21649 (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 03/09/04 Baltimore. Md. permit.
Dep. rtm
Impc rta
any nju 21. Signature of Fureral Service Licensee Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
237 E. Patapsco Ave. Baltimore, Md 21225 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Carajastive /
Due to (or as a consequence of): **Physician** Heart tallave Show /Medical Examiner End Stage Non Operable Covonory Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transit Coven avy Arter 4 Disease and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetet dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetet death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artificial NitvalValve **₩**Yes 2 🗆 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No this certificate has autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ s after do... rel Director: After ... by the funeral di Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 50996 3/6/64 TOO SOULCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cliestertain MD MD Neil Stockfair 100 Brei 31. Date filed (Month, Day, Yeer) 32. Registrar's Signatur State Boarks MAR 1 1 2004 Registrar

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G			1 _ State	State of Maryland / Department of Health and Mental Hygiel  Certificate of Death								2001. 071.20				
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	/Medic Examin		4a. Fecility Name (If not institution, gr	ve street and number)	1	4b. City, Town, or Location of Death							of Death	10.50		
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	Funeral		,	Sex 7. Ag 11∕27 M 2 ☐ F	e (In yrs. last birthda;	/) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)		9. Birth	olece (State ontry)	or Foreign	
	Director		213-82-0650 Usual Residence of Decedent		30 Yrs.					11 1	1	73	1	1D		
	/land		10a. State 10b. County		10c. City, Town or	ocation			10				T	10d. Inside C	ity Limits	
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	or 28	Director	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of V	What Cou	ntry?		
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	er deg	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		. Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	-		e - Ameri ck, White,	can Indian, etc.		
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ŏ	be filed within 72 hours after death with the Marylan Ital Hygiene. Ital Hygiene. In other than "natural", or Itama 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's E	Education	16a. Dec	edent's Usu	al Occupa	ition			16b. Ki	ind of Bu	usiness/In			
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and	be fill d otl	Be	u 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden S									i Sumame)				
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Baltimore,	permit. Pages 1 a Department of Hez Important: If Item any injury or othe		21. Signature of Funeral Service Lice	en see		2. Name ar arch								,		
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			23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line.  Immediate Class (Final disease or condition as Multipal guwww two works)  a. Multipal guwww two works.												ween	
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687	physics the b	dicai														
Box (	death certifical e attending phi id for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of delivery				
m.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		□Ectopic pr □ Other (sp	,					Mor	nth	Day 1	/ear	
P.0	The law requires that the death certifical to has been signed by the attending phyage 2 should be detached for use as the	by Physician/Medi	9 Unknown													
	signed d		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying c	ause give	n in Part I.		11				e cause of d		
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<u>a</u>	in: Th		25. Was case referred to medical					00 BI		1 XYes	2 🗆 No		Yes	2 No		
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10	ig Phy ter thi neral (		27. Manner of Death	28a. Date of Inju	ry 28b. Time		8c. Injury Work			28d. Describe h				1	Jene	
Siol	Attending r death. sctor: After by the fune	atic	1 □Natural 5 □ Pending 2 □ Accident investigation	on 3-7-0	. / \ ' '	7PM		es 2 21	No	Dolle	25CC	L K	Hio	1		
Division	l or Att	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 Homicide determined	28e. Place of Int	ury - At home, farm, s c. (Specify)	treet, factory	, office		1	28f. Location (S City or Tow	street and m, State)	Number 21 G	or Rura	I Route Numi	Per And	
	pital ours a eral D		29a. Certifier 1☐ Certifying P	hygician: To the best	NOY	ne			7	Saltin	word	161,	D 3	1220	7	
	To the Hospital or Attending Phyaician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medicel Exa	hysician: To the best miner: On the basis o and manner sta	f examination and/or i	nvestigation,	, in my op	e, date and inion, deat	h occurre	and due to the d ed at the time, d	date and	place, a	nner as si ind due to	ated. the cause(s)	r	
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)			Mar	VW	O.C.M.E. March								8, 2	2004		
	2		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type											
	2		S. R. HOG 31. Date filed (Month, Day, Yeer)	1 N	ar's Signatura	11	1 Per	nn St	reet	, Balti	more	e, Ma	aryla	and 212	201	
	Sta Registr		MAR 1 1 2004	JZ. Hegistr	ar's Signature	ee .										
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DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

MAR 1 1 2004

32. Registrar's Signature

				State of Marylar	_	artment of t rtificate of		•	giene Reg. No20	n I.	071.27
	Dharaia		1. Decedent's Name (First, Middle, Last)					2. Dete of Dea	ath		3. Time of Death
	Physici /Medi		Juanita		orrison	L		March	4, Dey 2004		4:05 pm
	Examir	ner	4a Fecility Neme (If not institution, give s	street and number)			4b. City, Town, or				
	Funeral		1207 Winer Road  5. Social Security Number 6. Sex	7. Age (In yrs.	lest birthday)	If Under 1 Year		8. Date of Birt	Anne		del lace (Stete or Foreign try)
ш	Director		114-36-5657	]м 2 <b>∑</b> [F] 58	Yrs.	Months Deys	Hours Min	March	28,1945		ginia
	end **		Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				Od. Inside City Limits	
	Mary Fled	ţ	Maryland Anne Arun	ide1		Odenton					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	het Coun	try?
	e 23e	ral	1207 Winer Road				1113		United		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examinst must be notified at once.	by Funeral	11. Maritel Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	-	Was Decedent of I f Yes, specify Cub I□ Yes 2 X No	Hispanic Origin? (S pan, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race Blac Specify	e - America k, White, a	
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e,	1 and Health Brm 27 ther tu		Marvin P. Morrison/ 20a. Method of Disposition			Viner Roa sition <i>(Name of</i>		on, Mary	1and 21		um State
JO T	Pages net of int; if its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other pla	1				
atti	Department Importariany Injure		21. Signature of Funeral Service License		22	ans_Ceme1 . Name and Addre	ess of Facility				Maryland
0	8 2 E 8		Juanta R Tho	ma- M00			Funeral oolis Roa				
			23a. Part Enter the disease, or complice shock or heart failure. List only on	ations that caused the deat e cause on each line.	h. Do not ente	er the mode of dyi	ng, such as cardia	or respiratory and	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	at	14.	0. 1					Onset and Death
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o.	tha day	hysi	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying cause given	ven in Part 1.		_		the cause of death?
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0	g Phys er this ieral d	n: To	27. Manner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	4 LI Nursing H	lome 5 Reside			
Sior	endin eath. or: Aft	atlo	1 Naturel 5 Pending 2 Accident investigation	(Monn, Day Your)	Injury		Yes 2 □ No				
	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Si City or Town		r or Rural	Route Number,
_	To the Hospital or Attending F within 24 hours aftar death. To the Funeral Director: After complataly filled in by the funer	edical Ce	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	clan: To the best of my known: On the basis of exeminat	wledge, deeth tion end/or inv	occurred at the tirestigation, in my co	me, date end place	, end due to the c rred et the time, d	ause(s) and mar ate and place, a	ner as sta	ited. the cause(s)
	To the within To the Youngle		29b. Signature and title of certifier	and manner steted.		29c. Licens	e number	2	9d. Date signed	(Month, D	ey, Year)
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			30. Name end eddress of person who com			Print)			1	,	
	$\mathcal{V}_{\mathcal{I}}$	0	MICHAIL FURIEU J. 31. Dete filed (Month, Day, Year)	48VMC 4970 32 Registrer's Signa		ATV AVE	, actition	iere, Md	1/2	24	
	Sta Registra	re	MAR 1 1 2004	A A	A.	AP A					

State of Maryland / Department of Health and Mental Hygiene 2004 07428 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2004 Alice W. Muth MARCH 11:30PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 124, Year 1915 7. Age (In yrs. last birthday) 88 yrs 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛛 F 120-01-1207 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, It a Medical Examinations in Item 1 at 1 MD Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Road 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Yes. Give Specify: 3X Widowed 4 □ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) researcher marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Wren 2 Adela Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Green/daughter 3738 Huntington Street NW Washington, DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronal Co. Wade 655 W. Baltimore Street man inication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. A ter the disease, or a mulicati shock, o heart failure. List only one c Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRAL EMBOLIZATION AND 3 day IN FARCTZON /Medical Due to (or as a consequence of): Examiner YEAK S TRIAL FLBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an 24a. vvas an autopsy performad? 1 ☐ Yes 2 ☑ No 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 10 the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funerel C completely filled 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14 1 053430 MARCH 7 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHARLES BALTZMORE MARYLAND 21204 FRED CHAN STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

			1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artmen tificate	t of H	lealth a D <i>eath</i>	and Me	ental Hy	giene Reg. No.	200	4	07	429
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Mary T. Moran								2. Date of Dea Month Februat	Day	8, 200		3. Time o	
	Examir		4a. Facility Name (If not institution, give				Tak	oma	Location o	of Death		4c.	County of D	eath nery		
Ì.	Funeral Director		5. Social Security Number 6. Security S	M 2X)F	74	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da) Jan 17,	y, Year)	9. Wa	Birthpla Country Shir	ice (State y) ngton	or Foreign LDC
	se Maryland Be-f show	ctor						ocation ma Park						10d. Inside City Limits 1 ☐ Yes 2√∑ No		
	ath with It	Funeral Director	10e. Street and Number 112 Park Avenue				10f. Zip		2091				zen of What USA	Countr	y?	
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Exeminer must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	1	Vas Deced fYes, spec I□Yes 2		ispanic Orig n, Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - A Black, W Specify:	/hite, et		
Baltimore, Maryland 21215-0036	within 72 ho iene. 'then "netu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or	5+)	16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us	k done d	turina most	of working	-		nd of Busine		•	
yland 2	d tal	To Be Co	Paul J. Schwarz  18. Mother's Name (First, Middle, Maid Paul J. Schwarz								Maiden .	ido e Cumama)			unl	
, Mar	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Ty, Jim Hardy/frier	•							Route Numbe Water,			a, <i>Zip C</i>	code)	
Imore	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic. ang.e.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R  `4 □ Donation 5 📉 Other (Specify)	in stat	, a	lace of Disposemetery, crem	sition (Nam natory or ot	e of her place	9)	Da	te	20c. Lo	cation - City	or Town	n, State	
Ra	permit. Pag Department Important: I any injury o		21. Signature of Proceed Secretary Ronal Constitution of March 1997	1 Class	ector	St Ba	ate A ltimo	nato re,	MD = 2	ard 1201	655 W.		timore	: St	reet	
	Physician /Medical Examiner		Approxima shock, or heart failure. List only one cause on each line.  Immediate) Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approxima Interval Be Onset and Onse												tween	
8/60,	*	al Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):													
O. Box 68/	death certific e attending p id for use as	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)								2	23d. Date of delivery  Month Day Yea			Year
ras, r	signed d be de	by P	Part II. Other significant conditions con	tributing to death t	out not resu	ulting in the un	derlying ca	use give	n in Part I.			bacco us	se contribute	to the	\ \	death? (Inknown
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r vital	> S D	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpati	ent 2 🗆 l	ER/Outpatient	3□ DO/	Othe	201119-0-2		Check only on	-	□Other (Sc	pecify)		
DIVISION OF	ending Pheath. or: After the	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time of Injury	28 M	c. Injury Work 1 🗆 Y		28	d. Describe ho			,		
Ž	To the Hospital or Attending Pr within 24 hours alter death. To the Funarel Director: After it completely filled in by the funeral	O	4 Homicide determined	28e. Place of In building, et	c. (Specify	")					f. Location (St City or Town	n, State)				ber,
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	To To Com	×	29b. Signal vr and title of certifier		Jo. (	/			number らこうし		2	9d. Date 3 / 4	signed (Mo	nth, Da	y, Year)	
		i	30. Name and address of person who con	mo mes	Rockui	LLE PIKE,	POCK	ins	MO 2	D 852						
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 2004	32 Registr	ar's Signa	yre Ans	de									

		4	For State	State of Maryland		ment of H			- 71111	L			
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  Tulicum.	Means				2. Date of Death Month D	ay Yeer 6 200				
<i>}</i>	Examin Funeral Director	er	5. Social Security Number 6. Sex	0-1-66-116	the political life of the state	0 -	Hours Min.	1	r) Co	th  CUNCE  tholace (State or Foreign buntry)  ryland			
	2		Usuel Residence of Decedent  10a State 10b. County Anne Arun		Town or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	death with the Maryland ms 23s or 28s-f show	_	10e_Street and Number 238 Long Point Ro	oad	1	Of. Zip Code	032		10g. Citizen of What Country? USA				
	n 72 hours after death with the Marylan "natural" or Items 23a or 28a-f ahow Alfrai Examinan must be nutitive at	by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Decedent of Hi s, specify Cuba Yes 2X No	spanic Origin? (Spec n, Mexican, Puerto F Specify:						
Maryland 21215-0036	within 72 hour ene. than "natural	Completed t	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 1 2	g 16b.	16b. Kind of Business/Industry								
yiana 2	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) Walter Harry Pike		Sect	(First, Middle, Maide a Estelle	Gordon	Zin Code)					
Баппоге, маг	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is merke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print)  Victoria Kuntz/daughter  238 Long Point Road Crownsville, MD 21032  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)										
Baitil	permit. P Departm Importar any inju		24- Signature 1 F. gerol Stryice Licenses	ade Descer			oss of Facility Omy Board MD 21201	655 W. Ba	ltimore	Street			
	Physician		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line.	Do not enter the	ne mode of dyin	g, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death			
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,092	te be executed ysician and ne burial-transit	cai Examiner	Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Deep Vein	ence of):	-	is			Many years			
Вох 68	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 M No 9  Unknown	Sc. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	topic pregnancy ther (specify)	,		23d. Date of de Month	blivery Day Year				
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Vital Records,		Completed				24a. Was an autopsy performed?	prior to death?						
	nysician: nis certific director.	To Be	27. Manner of Death	-	ER/Outpatient 28b. Time of Injury	3 DOA Oth	4 Zervursing Hor	ne 5 Residence 28d. Describe how in		ecify)			
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral	Certification:	1 Selection 1 Selection 1 Selection 1 Selection 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street	M 1 🗆	Yes 2 □ No	28f. Location (Street City or Town, Sta		Rural Route Number,			
_	Hospital 24 hours Funeral stely filled	ledical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death or ion and/or inves	ccurred at the tir tigation, in my o	me, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	(s) and manner a and place, and du	as stated. se to the cause(s)			
)	To the within To the comple	Med	29b. Signature and title of certifler	MD.		29c. Licens	rt02(d	ŀ	Date signed (Mor				
			30. Name and address of person who complicity in Nosarces				Busnie, 2	21061, Ma	gland.				
	St Regist	ate trar	31. Date filed (Month, Day, Year) MAR 1 1 200	32. Fegistrar's Signat	ure A	de							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Laurence McDowell February 27, 2004 7:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Glen Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Yrs. 1928 South Carolina Director 578-30-9634 March 20. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f show . It is Medical Examinar must be notified at 1 X Yes 2 ☐ No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 Barker St. USA death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after XYes 2 □ No f Yes, Give 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be tiled within Health and Mental Hygiene. Iam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Food 12th Cook other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorsey McDowell Mabel Unknown 2 of Health and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hines Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Peges ± ± 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 📉 Other (Specify) in state 0 permit. Pege Department o Importent: If any injury or 21. Sgnature of Euneral Service Licensee Ronald S Wade 22. Name and Address of Facility Hines-Rinaldi Funeral Home Director 11800 New Hampshire Ave. Silver Spring, MD 20904 mittell RULL 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician pneumonia weeks resulting in death) /Medical Due to (or as a consequence of): Examiner bacteremia Sequentially list conditions, if any, leading to infinite shade cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dile to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No detached 9☐ Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 10 1 🗌 Yes 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 1 ☐ Yes 2 ☐ No certificate 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA (his After thi 27. Manner of Calh 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending ospitel c. 4 hours after dea... rel Director: Afte 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D 0053528 March 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2309 Shorefield Road Wheaton, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 11 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Box 68760,

P.O.

State of Maryland / Department of Health and Mental Hygiene 2004 07432 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MICKEL TRAVIS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MULO widol Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1<del>√2</del> M 2□ F Months Hours Min. 25 Director 184-68-5891 ancaster, Pa. Aug. 14, 1978 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itama 23e or 28e-f ahow other traumatic event. The Mississ Exercises must be notified at 1 ☐ Yes 2 ☑ No Director Lancaster Lancaster Pa. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2130 Kentwood Drive

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 Never Married 2 Married

1 Yes, Give Year or Dates: 17601 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after Maryland 21215-0036 Š 1 ☐ Yes 2 No Specify: white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Itam 27 ts marked other th any injury or other traumatic event. The Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Craig A. Mickel ပ Susan J. Minney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 Kentwood Drive, Lancaster, Pa. 176()1

Date 20c. Location - City or Town, State Craig A. Mickel/father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Burial Vault3/12/04 Leola, Pa. 17540 Creamatory and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral S 5555 Twin Knolls Road, Columbia, Md. 21045 23a. Part1. Enter the disease, or an lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** HYPOTENSION 5 HOURS resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE 2 DAYS RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed PNEUMONIA and Due to (or as a consequence of): **burial-1** P.O. Box 68760, the attending physician EWINGS Physician/Medical 18 MONTHS SARCOMA as the IF FEMALE: **08**0 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy page performe certificate 2 8 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature of d title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MEDICAL DOCTOR RES MARCH, 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COSGROVE, JOHNS HOPKINS HOSPITHL, GOD NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287 31. Date filed (Month Day 2. Registrar's Signature 1 2004 State Registrar

			For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	ind M	ental Hyg	jiene Jeg. No. 2	2004	07433
I	Physici		1. Decedent's Name (First, Middle, La: Sophie Mitt								2. Date of Dea Month March	th Day	Year	3. Time of Death 1:30 p M
	/Medic		4a. Facility Name (If not institution, giv	e street and numb	per)		4b. City, T	Town, or	Location o	f Death			ounty of Death	
ı			13408 Clifton Ro	oad					r Spr			M	lontgom	ery
	Funeral Director		2/3-05-0483	ex 7. □M 2X F	. Age (In yrs. Ia 89	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Jan。15	, Year)	9. Birthr Cour 5 Ru	place (State or Foreign ntry) SSia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
	a Many	Director	MD Montgo	omery	В	ethes	la							XXYes 2 □ No
	with th	Dire	10e. Street and Number 6514 E. Halbert	Pond			10f. Zip (	Code 0817					n of What Cour	*
	ms 23	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. )			spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)		Race - Americ	ean Indian,
36	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-f show that the Macical Exemple in the netified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	ŒNo	1	f Yes, speci 1 ☐ Yes 2		n, Mexican, Specify:	, Puerto l	Rican, etc.)	Sp	Black, White, pecify:	<sub>etc.</sub> white
2	72 hor	eted	15. Decedent's & (Specify only highest gra			16a. Deced	dent's Usual	Occupa k done d	tion urina most	of working	20	16b. Kind	of Business/In	dustry
727	y within jiene. r than "	Completed by	Elementary/Secondary (0-12)	College (1-4 +5	lor 5+)		kind of work DO NOT use Oraria		uning most	or womin	<i>'</i> 9		Libra	ry
Baltimore, Maryland 21215-0036	m = 0 %	To Be C	17. Father's Name (First, Middle, Last, Sam Speiglman								(First, Middle, eisler	Maiden Su	ımame)	
Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ia marked any injury or other traumatic en	_	19a. Informant's Name/Relationship ( John Mitrisin, S				-				Route Number Bethes			
ore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from St	ate ce	ace of Dispo	sition (Nam natory or ott	e of her place	)	3/10	ate	20c. Loca	tion - City or To	own, State
altim	rmit. Pa spartmen portant: y injury ice.		`4 □Donation S □ Other (Specification of Specification o		Bal	timore /22					eral an		imore,	
m 	8958		23a Part1 Enter the disease, or com	YW	Lat,	14	1040 K	locki	<u> </u>	Pik	e Rockv	ille	MD 208	352
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	cardia				, such as t	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death Sudden
	/Medical Examiner		resulting in death)	Due to (or	as a consequence	ence of):								Budden
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a conseque									
	xecutar and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·	heimer		ease							
8760	icate be executad physician and s the burial-transit	dicai	(	d. Str	oke							_		
.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		h 2 ☐ Fetal on t at time of dea	death 3□	Ectopic pre Other (spe					230	I. Date of delive	ery Day Year
_	es tha	by	Part II. Other significant conditions of	ontributing to dea	th but not resul	lting in the u	nderlying ca	use give	n in Part I.					ne cause of death?
ecor	e law requir has been si je 2 should i	Completed									24a. Was a	n 2	24b. Were auto	psy findings available mpletion of cause of
E H		e Con	25. Was case referred to medical									2 No	death?	2 No
$\equiv$	ysicie is certi directo	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	patient 2 E	R/Outpatien	t 3 DOA	Otho	26. Place r: 4 □ Nur	of Death	(Check only on ne 5 ☐ Reside	ence 6XT	Other (Specific	Group
on o	ding Ph th. : After thi funeral		27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time of Injury		c. Injury Work	at ? ′es 2□N	2	8d. Describe ho	ow injury o	ccurred	у ноше
Division of Vital Records,	I or Attandi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of	f Injury - At hor , etc. (Specify)	me, farm, str	eet, factory,	office		2	8f. Location (Si City or Town	reet and N n, State)	lumber or Rura	l Route Number,
	Hospita 4 hours Funeral	Medical Co	29a. Certifier 11 Certifying Pt (Check only one)	nysician: To the be niner: On the bas and manne	is of examination	vledge, death on and/or inv	occurred a	t the time	e, date and inion, deat	d place, a h occurre	and due to the co	ause(s) an ate and pla	d manner as si ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manne	. 3.0.00		29c.	License	number		2	9d. Date s	igned (Month,	Day, Year)
	~		- Letino	am	2			D <b>~</b> 32	2332		Ma	arch	8, 2004	
	13		30. Kame and address of person who					<u>.</u> 1 .	C		MD C	2000		
	Sta	te_	Dr. S.K. Gupta 31. Date filed (Month, Day, Year)	221 <sup>9</sup> Pag	Georgia gistrar's Signatu	150		11ve	r Spi	ring,	, MD 20	902		
	Registr		MAR 1 1 20	34 Asola	Jistrar's Signati	A SA	well !							

		1	_ State	epartment of Health and M Certificate of Death	lental Hygiene Reg. No. 2004 07434
	Physicia	7546	1. Decedent's Name (First, Middle, Last) MILDRED	MILHISER	2. Date of Death MARCH 8ay 2004 8:50P M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) FUTURE CARE CHERRYWOOD	4b. City, Town, or Location of Death REISTERSTOWN	4c. County of Death  BALTIMORE
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birt) 1 M 2 F  88  Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  OCT 11,1915  9. Birthplace (State or Foreign Country)  MARYLAND
	Maryland I show		10a. State 10b. County 10c. City, Town MD BALTIMORE	BALTIMORE	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the 23a or 28e st be not	Funeral Director	10e. Street and Number 16 OLD COURT RD., #519	10f. Zip Code 21208	10g. Citizen of What Country? USA
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural; or tiems 23s or 28s-f show other traumatic event, the Medical Exam naturalize multiplied at other traumatic event,	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No It Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Specify: WHITE
215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Dccupation (Give kind of work done during most of work life. DO NOT use retired)  SUPERVISOR	ing NURSING HOME
ุด	tal Hygien of other th	Be	17. Father's Name (First, Middle, Last)  OSCAR SCHERR		e (First, Middle, Maiden Sumame)
Maryland	should and Men is marke aumatic	ဥ			al Route Number, City or Town, State, Zip Code)
	is 1 and 2 is 1 Health ar item 27 is other trau		20h Place o		MONIUM MD 21093 Date 20c. Location - City or Town, State
Baltimore,	Pages ment of ant: If it ury or o		*4 □Donation 5 □Other (Specify) BETH		0/04 FINKSBURG, MD
Balt	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	8900 REISTERSTOWN	LEVINSON & BROS., INC. RD. PIKESVILLE, MD 21208
1.00	Physician		23a. Part. Enter the disease, or comblications that caused the death. Do shock, or locart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	not enter the mode of dying, such as cardiac	
	/Medical Examiner		resulting in death)  Due to (or as a consequence	of):	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	
, 1092	be executed sician and burial-transit	cai Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):	
.O. Box 687	The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
<u>α</u>	ires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Records,	law requires t has been signe e 2 should be o	Completed	Atvine fil		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
al H	n: The ficate I or, pag		25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No ath (Check only one)
Vital	Physician: this certificantal director,	To Be	examiner?  1  Yes 2 No	Other	lome 5 Residence 6 Other (Specify)
on of	Attending Phy or death. ector: After thi by the funeral of		27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	Time of Injury At Work?  M 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred
Division	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospita 4 hours Funera ely fille	icai (	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
<b>\</b>	To the within 2 To the comple	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Q.		30. Name and address of person who completed cause of death (Item 23a	(Type, Print)	uene Tree 2/208
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	10.5	
D	Regis HMH 17 Rev 1.	1 %	MAR 1 1 2004 Peners	Aparks RIGINAL	

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** March 1, Lucille Nelson 2004 Marie 4:42pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 20 F Yrs Director 81 489-22-0985 20, 1923 Missouri Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo <u>Maryland | Anne Arundel</u> Gambrills 6 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2513 Flowering Tree Lane 21054 United States 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Yas 2 XNo Specify: þ Specify 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Typist Advertising Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 and 2 should be fitteent of Health end Mental Hant: If Item 27 is marked ott Be 0scar Henry Heinbach Marie 2 Lena Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gretchen Roberson/ Daughter 2513 Flowering Tree Lane Gambrills, Maryland 21054 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State Department of Fingortant: If ite any injury or ot cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 3/6/2004 St. Louis, Missouri 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee M00957 antig 1411 Annapolis Road Odenton, Maryland 21113 thomas 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Metabolic Encephalopathy Hours Examiner Due to (or as a consequence of): Examiner Acute Renal Failure Days The law requires that the death certificate be executed been signed by the attending physiclan end should be detached for use es the burial-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Myocardial Infarction Hours Physician/Medical Due to (or as a consequence of) resulting in deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? has certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 1 ☐ Yes 1 TInpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death t hours after death. uneral Director: After the aly filled in by the funere 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide ò To the Hospitai within 24 hours of To the Funeral I complataly filled Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only and title of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) March 8, 2004 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar Henry F. Davis, M.D.

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

book!

32 Registrer's Signature

De Flores

Anne Arundel Medical Center Annapolis, Maryland 21401

State of Maryland / Department of Health and Mental Hygiene 2004 07436 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 10,2004 **Physician** Abraham George Osler 10:04a<sup>M</sup> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Vantage House Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Stare or Months | Days | Hours | Min. | May | 16, 1911 | N.Y., N.Y. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 92 220-30-4198 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23s or 28a-1 show any injury or other traumatic event, the Medical Examiner must be multiled at once. TX Yes 2 No MD Howard Columbia Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5400 Vantage Point Road 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University Professor Johns Hopkins Univ 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Osofsky Fannie Weinstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cope T1 P8 19a. Informant's Name/Relationship (Type, Print) Margaret Osler/Daughter 1805 30th Ave.S.W. Calgary, Alberta, Canada 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/11/04 Chesapeake Crem. Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of yneral Service Lions PHILIP D. RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): use as the burialattending physician P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic oregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) assisted Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death

To tha Funaral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MNC6 10,2004 30. Name. of person who completed cause of death (Item 23a) (Type, Print) Clumber no LITTLE DIENGE 1/01) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 1 2004 Registrar

			For State Registrar		State	of Maryla		artment of H		d Mer		ene 21	004	07	437
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	Examin	er	KARTH A	PUNC	EL	HOSPI	TAL	GLEN	BURN	JIE		ANN	Α.	and	EL
	Funeral		5. Social Security Number	6. Sex	M 2□F		a. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, )	(ear)	9. Birtho	place (State or	r Foreign
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G, AC imore, M	of Healt of Healt if item 2		20a. Method of Disposition 1   Burial 2   Crema	ition 3 □B	emoval from	State C	Place of Dispo cometery, crea	sition (Name of matory or other plac	) Mar	^ch <sup>Date</sup>	12	c. Location	- City or To		
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Bal	permit. Page Department Important: In any injury o		21. Signature of Funeral Se	rvice License	*\J_'	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	22	2. Name and Addres 3111 Mout	Commence and the same		Stallir Pasade				Р.А.
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۵ ۳	To the Hospitel or Attem within 24 hours after deatl To the Funeral Director: completely filled in by the	al Cer	29a. Certifier	tifying Phys	sician: To th	e best of my kr	nowledge, deat	h occurred at the tim	e, date and p	olace, and	due to the cau	se(s) and m	anner as si	ated.	
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	1 1/		30. Name and address of pa	erson who co	mpleted cau	se of death (Ite	om 23a) (Type.	Print), 1	000			iano	7 10	124	0 4
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1	Sta	ite	31. Date filed (Month, Day,	Year) 1 20	10.4 32. F	Registrar's Sign	nature	Cart :							

JOANN M.PIERCE UNK 04-066 04-01675 RJ

> Physic /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or Iteme 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospitet or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Maryland / State of Maryland / State	/ Depa <i>Cer</i>	rtment of H tificate of I	lealth i Death	and M		iene2 ()	04	07438
an	Decedent's Name (First, Middle, Last)  JOANN M. PI	ERCE				2. Date of Deat Month March 6	Day	Year	3. Time of Death 5:00 P. M
eal er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location	of Death		4c. Count	y of Death	
	Harbor near Fort McHenry		Baltim				N/	A	
	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	place (State or Foreign htry)
	083-34-5002 1 M 2 M F 62  Usual Residence of Decedent	113.				Apr 12,	1941	New	York
	10a. State 10b. County 10c. City, To	own or Loc						1	0d. Inside City Limits
ctor	New Jersey Cumberland		Vinela	ınd					1√ Yes 2 No
Completed by Funeral Director	10e. Street and Number 573 Royal Drive		10f. Zip Code	083	60	10	g. Citizen of USA		itry?
ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Or	igin? (Spi	ecify Yes or No-		ce - Americ	
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Be C	17. Father's Name (First, Middle, Last)	- 0				e (First, Middle, N	laiden Suma	me)	
To B	William Fitzgerald			Ma	rjor	ie LaP	ointe		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Numb	er or Rura	al Route Number,	City or Town	, State, Zip	Code)
	Thomas Pierce (Husband)	573	Royal Dr.	., V	inel	and, NJ	08360	)	
	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	of Dispos etery, crem Paul	ition (Name of atory or other place s Cemete	ery			oc. Location Hudson		
	21. Signature of Funeral Service Licensee Kevin E Ecker	Mc 1	Cully Po BO E. For	sof Facili	k Fu	uneral He Baltimore	ome, P	.A. 2123	30
	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.								Approximate Interval Between
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edical Examiner	ritary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,							
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sici	in the past 12 months?  1 Yes 2 No  9 XUnknown  1 Unknown		Other (specify)				M	onth	Day Year
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To B	examiner?	Outpatient	3□ DOA Othe			n <i>(Chack only one</i> me 5 ☐ Resider		er (Specify	
<u>-</u>	27. Manner of Death 28a. Date of Injury 28t	o. Time of Injury	28c. Injury Work		3	28d. Sescribe hov	v injury occur	red	and was
atlo	Accident investigation 3-6-04 U	n Kr		res 2 🔀	No T	429 000	draw	20000415	14
tifle	3 ☐ Suicide 6 ☐ Could not be determined 289. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		1	28f. Location /5th	et and Numi	per or Rural	Route Number,
Cer	15a	Utim	WE HZ	000		Bot	home	7	AD CI
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled XXMedical Examiner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the timestigation, in my op	e, date an pinion, dea	d place, a th occurr	and due to the cared at the time, da	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)
Σ	29b. Signature and title of certifier.	4	29c. License O. C.M			29	<sup>d. Date signe</sup> March		
	Talu brong - tall	de	CORP	0			011	,, 20	,,,,,
	30. Name and address of person who completed cause of death (frem 23)	а) (Туре, Р	111 Pen	n Str	æet,	Baltimo	ore, Ma	rylar	xd 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Dhue:	•	- For Amend Item #1 State of Maryland / Department of Health and M Registrar Certificate of Death	Reg	No. 2001	0743
	120	1. Decedent's Name (First, Middle, Last) LISA A. PIERCE	2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		DION N. TIDNOD	MARCH	8. 2004	10:47P.
Exami		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	1
		HARBOR HOSPITAL CENTER BALTIMORE CITY		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	nplace (State or Foreig
Director		138-78-2826 14 20F 35 Yrs.			aryland
>		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limit
a hov	_	New Jersey Bergen Lyndhurst		,	1X Yes 2□N
Sa-f	cto				
or 2	Director	10e. Street and Number 646 Chase Avenue 10f. Zip Code 07071	10g	. Citizen of What Cou	untry?
jiene. rrthan "natural", or items 23a or 28a-f ahow Ita Medical Examinar musi ke motified at				USA	
tem a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto for the Status of Hispanic Origin? (Specific Yes, Specify Cuban, Mexican, Puerto for the Status of Hispanic Origin? (Specific Yes, Specify Cuban, Mexican, Puerto for the Status of Hispanic Origin? (Specific Yes)	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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han M	E	Elementary/Secondary (0-12) College (1-4or 5+)	&	Wellness	programs
I Hygiene other the		12 5+ ASSISTANT DIRECTOR  17. Father's Name (First, Middle, Last)  18. Mother's Name			
la de la de	Be		M. Fitz		
nd Mental marked o	은				:- C-4-)
E .		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Thomas Pierce (Father)  19b. Mailing Address ( <i>Street and Number or Rura</i> 573 Royal Drive, Vinel		ity or Town, State, Z 08360	ip C008)
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5 <u>-</u> -		comptony cromatony or other place)		c. Location - City or 1 udson Fall	
ant: ury c		4 Donation 5 Dotter (Specify)			rs, MI
Department Important: I any injury o		21. Signature of Funeral Service Licensee Kevin E Ecker McCully Polyniak F 130 E. Fort Ave.,	uneral H Balto.,	ome, P.A. Md. 2123	30
195		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	r respiratory arrest		Approximate Interval Between
		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Ol: a		Onset and Death
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been signal	Completed		-		
	Jple		24a. Was an autopsy	prior to c	topsy findings availal ompletion of cause of
2 8	Con		performe 1 ☐ Yes 2		2 🗆 No
2 5	Be (	25. Was case referred to medical examiner?	(Check only one)	•	
2 2	To	Hospital:	ne 5 🗆 Residend	e 6 □Other (Spec	ify)
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is certificate has director, page 2		3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office	City or Town !	olater -	
is certificate has director, page 2		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	Herzo [4	New Fort
is certificate has director, page 2	Certification:	3 Suicide 4 Homicide  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place, a country of each occurred at the time, date and place a country occurred at the time, date and place a country occurred at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place at the time, date and place a	City or Town, Self-imere	se(s) and manner as	Ner Fort More HC stated.
is certifica director, p	edical Certification;	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only office)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and married stated.	City or Town, so the call at the time, date	se)s) and manner as and place, and due	More Ho stated. to the cause(s)
r death. ector: After this certificate has by the funeral director, page 2	Certification:	29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number	City or Town, such that the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)  , Day, Year)
is certificate has director, page 2	edical Certification;	29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number  O.C.M.E.	City or Town, such that the caused at the time, date	se)s) and manner as and place, and due	stated. to the cause(s)  , Day, Year)
is certificate has director, page 2	edical Certification;	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only Check	ind due to the call at the time, date	sels) and manner as and place, and due.  Date signed (Month) RCH 9, 2004	stated. to the cause(s)  Day, Year)
is certificate has director, page 2	edical Certification;	29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only office)  29b. Signature and title of certifier  29c. License number  O.C.M.E.	ind due to the call at the time, date	sels) and manner as and place, and due.  Date signed (Month) RCH 9, 2004	stated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2004 Month **Physician** Phipps 2:05am Erma Marie March 5 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Manor Care Rossville Rossville Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 9, 1931 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔀 F 72 Director 218-26-7577 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any Injury or other than any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 ☐ No Rosedale Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6619 Kenwood Ave. 21237 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Bank 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fredrick H. Komber ဥ Agnes Pruchniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Hartman / son 54 Berkshire Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/8/04 Baltimore MD BayviewCrematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 MAce Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or un plications that caused the deating by the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Limit finly one cause on each line. Onset and Death **Physician** HYPOXIA Immediate Cause (Final disease or condition resulting in death) /Medical Examiner DASY ( Due to (or as a consequence of) Physician/Medical Examiner ACCIDENT EKEBROVASCULAR The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 TO 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 No this ō 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Division 1 Natural 1 TYes 2 TNo 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 To rtifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D\$\$306 r 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1232 PROCES SUITE 203 ROSSUILCE PROFF, CTR BACTO- MD 21237 DENNIS HODIE 31. Date filed (Month Par Pred) 1 2004 State Registrar

DHMH 16 Rev 6/95

fo

Date

State of Maryland / Department of Health and Mental Hygiene 2004 07441 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MANUE 4:33PM March 21 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Baltimore Sinai Hospital of If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov 1, 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthptece (State or Foreign Country)
 UTIK **Funeral** 1X M 2 □ F 86 Yrs Director 217-01-4305 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Madical Exeminer must be notified at 17 Yes 2 □ No MD Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ō 2533 Loyola South Way or Itams 23a 21215 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if them 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Frederic 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: mexican Specify white δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) unk College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ☒ Other (Specify) in State 21. Signature of Funeral Service Licensee NOTHE +0 S. Wade, State Anatomy Board 655 W. Baltimore Street mas Baltimore, MD 21201

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Artery **Physician** Coronary Disease 40 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner tor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Hypertension Be Completed My ocardial infarction 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, examiner/ 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. March 2, RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltmore Rachel Hartman M.D. Sinai 2. Registrar's Signature 31. Date filed (Month, Day, Year) MAR I 1 2004 State Registrar

Manuel

	1- State of Maryland / Department of Health Certificate of Death	i and Mental Hygiene h	
Physician	1. Decedent's Name (First, Middle, Last)  Frederick Martin Pryor	2. Date of Death Month Day March 7.	y Year 3. Time of Death 2004 445 p. N
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 6302 Setting Star Columbia	n of Death 4c.	County of Death Howard
Funeral Director	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) 169-26-4907  Variable Properties  7. Age (In yrs. last birthday) 4. Months Days Hours  1. Age (In yrs. last birthday) 4. Months Days Hours  1. Age (In yrs. last birthday) 4. Months Days Hours	er 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 7	9. Birthplace (State or Foreig Country) 1934 PA
ocath with the maryland me 23a or 28a-1 chow troug be notified at	10a. State 10b. County 10c. City, Town or Location  Maryland Howard Columbia	a	10d. Inside City Limit
23a or 28a-f el	10e. Street and Number 10f. Zip Code 21045	10g. Citi	izen of Whal Country?
ture!' or Iteme 23s	11. Marital Status  1 Never Married  1 N	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
within 1.2 hours are bean with the waryanglene.  1. The Medical Examinational De notified at  Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during m Iffe. DO NOT use retired)	lost of working	ind of Business/Industry
od other event,		ther's Name (First, Middle, Maiden nna Mary Marti	
item 27 is marke other treumatic.	19a. Informant's Name/Relationship (Type, Print)  Marcilene S. Pryor, Wife  6302 Setting S	nber or Rural Route Number, City o	or Town, State, Zip Code)
nent of Hea ont: If item ? ury or other	20a. Method of Disposition  1	Date 20c. Lo	ocation - City or Town, State
Department of the post of the	21. Signature of Funeral Service Licensee P. 37 Osnleute. 22. Name and Address of Fac	5555 Twin Kr	
physician and the buriat-transit the buriat-transit dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events		Approximate Interval Between Onset and Death  Characteristics  Onset and Death
d by the attending physician and letached for use as the buriat-transit Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
igned by the be detache by Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	× /	use contribute to the cause of death?
cate has been s page 2 should		24a. Was an autopsy partormed?	24b. Were autopsy findings availa prior to completion of cause of death?  1 □ Yes 2 □ No
within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag.  Medical Certification; To Be Co.	examiner? Haspital:	ace of Death (Check only one)  Nursing Home 5 × Residence  28d. Describe how injur	
urs after death. rel Director: After I lied in by the funers Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, State	,
within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation, in my opinion, date of examination and/or investigation and date of examination and/or investigation and date of examination and/or investigation and date of examination and date of exa		and manner as stated.  d place, and due to the cause(s)  te signed (Month, Day, Year)
	) (B) (2) 4113	0	~ ch 9, 2004
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Clement B. Knight, M.D. 11065 Little Patus  31. Date filed (Month, Day, Year)  A. Registrar's Signature	xant Pkwy,Colu	umbia, Md.21044

			1 - For State Registrar	State of Mar	yland / Depa <i>Cei</i>	artment of H rtificate of L	lealth and M Death	lental Hygid Reg	ene 2 (	004	07443
	Physici /Medi		Decedent's Name (First, Middle, Last     RUTH	)		PEAR		2. Date of Death Month March	Day	Year 2004	3. Time of Death
	Examir			f Baltime		Baltimo			4c. County		N/A
	Funeral Director		5. Social Security Number 6. Se 213-32-9872 Usual Residence of Decedent	M 2 1 F 7. Age (/	n yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) SEPT. 30	1934	9. Birthpl Coun	ece (State or Foreign try) MD
	a-fahow	ctor	10a. State 10b. County N/		Oc. City, Town or Lo	cation	BALTIMO	RE		10	Od. Inside City Limits
	ath with the	Funeral Director	10e. Street and Number 6701 PARK HEIGHTS	AVENUE #3	-A	10f. Zip Code	21215	100	g. Citizen of		try? U.S.A.
936	72 hours after death with the Marylan natural", or itema 23a or 28a-f ahow disal Examiner mara ke molified at	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	ı	Was Decedent of Hi f Yes, specify Cuba I□Yes 217 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
21215-0036	n 72 hc	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e com <i>pleted)</i> College (1-4or 5+)	16a. Deced (Give life. (		ation Juring most of works )	ing	Sb. Kind of B		ustry
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, It a M	To Be C	17. Father's Name (First, Middle, Last)  IRVIN		СОНЕ		18. Mother's Name	a (First, Middle, Ma		78)	BLUMBERG
	ss 1 and 2 sho of Health and I item 27 Is me r other traums		19a. Informant's Name/Relationship (Ty BRIAN BROWN / SON		1231	8 TIMBER	GROVE ROA	al Route Number, C AD - OWIN	IGS MI	LLS, N	MD 21117
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	lemoval from State	ARLINGTON	CHIZUK A	MUNO 3/10	0/2004		_TIMOF	RE, MD
Ba	permit. Departriments Imports any inju		23a. Part1. Enter the disease, or compl	cations that caused the	~ 8	900 REIST	ERSTOWN I	L LEVINSO ROAD - PI	<b>KESVII</b>	LE, N	MD 21208 Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resutting in death)	ne cause on each line.	Myocaro	ud I	foretr	on			Interval Between Onset and Death
38760,	cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate audies. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
.O. Box 687	The law requires that the death certificate tile has been signed by the attending phy age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dai	te of deliver	y Day Year
<b>D</b>	w requires that been signed b should be deta	þ	Part II. Dther significant conditions cor	ntributing to death but n	ot resulting in the un	derlying cause give	n in Part I.				e cause of death?
Vital Records,		e Completed	Or Wes						d2 5	Were autoportion to compleath?	sy findings available pletion of cause of
of	ling Physic I. After this ce uneral direc	To B	27. Manner of Death 1 Natural 5 Pending	lospital: 1  lnpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at Nursing Hor	me 5 Residence 28d. Describe how			
Division	al or Attending s after death. I Director: After d in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, stre Specify)			28f. Location (Stree City or Town, S	at and Numb State)	er or Rural	Route Number,
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier 1 ✓ Certifying Phys (Check only one) 1 ✓ Certifying Phys □ Medical Examin	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the caus ad at the time, date	e(s) and ma and place, a	nner as sta and due to t	ted. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	K. M	1.0.	29c. License		No.	Date signed	/	
	ID		30. Name and address of person who co	ALI M.B.	2401	Print) West Fact	vedere A	77 rve, Balt	inou,	Mà	21215
	Sta Registr	24	31. Date filed (Month, Day, Year)  MAR 1 1 2004	32. Registrar's	Signature						

			1 - For State Registrar	State of Maryl	and / Depa		Health and	d Mental Hyg	•	
ĺ	Physici /Medio		1. Decedent's Name (First, Middle, Las Elizabeth T. Riter					2. Date of Deat Month March	Day Yea 4, 2004	4.4
	Examir		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of De		4c. County of De	path
_			Bon Secour Hospita  5. Social Security Number 6. Social Security Numbe		yrs. last birthday)	Balti If Under 1 Yea		frs. 8. Date of Birth	n/a	litheless (Clate or Francisco
	Funeral Director			☐ M 2[X]F	83 Yrs.	Months Day		in. (Month, Day, Feb 20,		lirthplace (State or Foreign Country) irginia
	Maryland -f ehow lied at	tor	10a. State 10b. County Maryland n/a	100	City, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No
	wirn the Sa or 286 Lbe noti	i Director	10e. Street and Number	· · · ·		10f. Zip Code			0g. Citizen of What	
	o winn / 2 nouts aller dean win he maryland jene. Then "naturel", or Items 23a or 28e-f ehow The Medical Examiner must be notified at	by Funerai	1935 Christian Str  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ĺ	2122 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	Hispanic Origin? Juban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Jnited Sta 14. Race - Ar Black, Wi Specify: W	nerican Indian, nite, etc.
	nen ''nature nen ''nature nen ''nature	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0·12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of v	working	16b. Kind of Busines	s/Industry
i	3 5 -		12 17. Father's Name (First, Middle, Last)	0	home	maker	18 Mothor's N	lame (First, Middle, N	home	
	a a a	To Be	James Bryant					unknown	alden Surname)	
	7 le m		19a. Informant's Name/Relationship (7) Donna Barrett - da		1			Rural Route Number, eston, Mar		, <i>Zip Code)</i>   655
3	rages 1 and and of Healt it: If item 2 y or other		20a. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specify	Removal from State	*	natory or other p			20c. Location - City o	or Town, State
	permit. Pages Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licen		22	. Name and Add	ress of Facility H	lubbard Fur	neral Home	e, Inc.
	1		23a. Part 1. Enter the disease, ir companies shock, or heart failure. Lift on y	cations that caused the c						Approximate Interval Between
	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Myocardia Due to (or as a con		tion				Onset and Death Immediate
Ś	ns tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor:	sequence of):					1
	ite be executed lysician and ne burial-transit	cai	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					ļ l
	at the death certaincate by the attending physi- tached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnan	су		23d. Date of d	elivery Day Year
	pe de	by	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause o	iven in Part I.			to the cause of death?  Probably 4XIUnknown
	ate has b	Completed						24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of
	this certificate	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of D	eath (Check only one	)	
i	ne ite	lon: To	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Inj	ury at ork?	Home 5 Resider		ecify)
	18 19 19 19 19 19 19 19 19 19 19 19 19 19	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)		Yes 2 No	28f. Location (Str. City or Town,		Rural Route Number,
	within 24 hours after de To the Funeral Direct completely illed in by the	dical	29a. Certifier (Check only one)  1 XCertifying Phy 2 Medical Exam	vsician: To the best of my iner: On the basis of examend manner stated.	knowledge, death nination and/or inv	occurred at the restigation, in my	time, date and pla opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
1	within To the comple	Me	29b. Signature and title of certifier	1/1	4 ^		nse number		d. Date signed (Mor	
C			30. Name and address of erson who d	ompleted cause of death (	17 , L) , Item 23a) (Type,	D23			March 11,	2004
U			405 Frederick Road	100	MOIET		1CK W. W.	hite M.D.		
	Sta Registr		31. Date filed (Month Dy Year)	2004 32. Redistrar's Si	gnature	Mark!				

			For State Registrar	State of M	aryland /		artment of F rtificate of		Mental H	ygiene Reg. Na	- Z 11 11 U	074	4
	Db(a)		Decedent's Name (First, Middle,	Last)					2. Date of D			3. Time of Dea	ath
	Physici /Medi		Kaymond				Ric.	e	WARC	h 10	2004	13:00	М
1	Examir	ner	4a. Facility Name (If not institution,	give street and number)	1 1		4b. City, Town, o	or Location of Dea	ith	40	. County of Death		
				Sex 7. Ac	Di tal	hirthday	If Under 1 Year	If Under 24 Hr	s. 8. Date of B	ieth	O Birth	alaaa /Ctata au Ca	
Н	Funeral Director		160-64-6422	192 M 2□F	35	Yrs.	Months Days	Hours Mir	. (Month, E	ay, Year)	Cou	place (State or Fo. ntry) ISVIVania	_
	סי		Usuel Residence of Decedent		T				Oct.	20, ]	1968 Peni	15 y I Valific	
	anylan show	_	10a. State 10b. County		10c. City, To							10d. Inside City Li	
	Ba-1	ecto		iberland	Wat	sont						1 Tes 2	₹INO
	with t	ä	10e. Street and Number 209 Hughes Road	1			10f. Zip Code 177	77		-	tizen of What Cou Lted Stat	•	
	leath	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13			Specify Yes or N		14. Race - Ameri		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at ODGe.	by	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Puè	rto Rican, etc.)		Black, White, Specify:		
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education	16	Sa. Dece	dent's Usual Occup	pation during most of we	orkina	16b. K	(ind of Business/In	dustry	
2	Althin Den Pen	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)	, may		_		
	iled v tygie ther ti		12 17. Father's Name (First, Middle, La	etl		Lak	orer	19 Mothodo Na	me (First, Middle		Process	sing Fact	or
and	d be f antal h	o Be	Earl C. Rice, Jr						L. Smit		i Sumame)		
Maryland	should Me mark	ဥ	19a. Informant's Name/Relationship		15	9b. Mailir	ng Address (Street				or Town, State, Zin	Code)	
	nd 2 alth a 27 is		Angela J. Rice -	Wife			lughes Ro		ontown,				
Baltimore,	of Her item		20a. Method of Disposition		20b. Place cemei	of Dispo	sition (Name of natory or other place	ce)	Date		ocation - City or To	own, State	-
<u><u>Ĕ</u></u>	Page ment ant: If ury o		1 ☑ Burial 2 ☐ Cremation 3  • 4 ☐ Donation 5 ☐ Other (Spe		St. Jo Churc	ohn's ch Ce	Luthera	$n \mid 3/1$	15/04	clint	ton Twp.	, PA	
alt	epartr epartr nports ny inje		21. Signatur Service Li	ensee		1 00	44						
_	70 E 2 9	110	23e. Part 1. Enjer the disease, or conshock, or heart failure. List or	M	01280	72	250 Washi	ngton Bl	neral H	ome A krida	at MMP., <del>de, Marv</del> i	Inc. land 210'	75
-	- A State			implications that caused by one cause on each li	the death. Done.	o not ent	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,	,	Approximate Interval Between Onset and Death	1
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		respira		/ Distr	ess Sy	ndrom	0		1 weak	
	Examiner			Due to (or as	a consequenc	e of): /		,				1 10	
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequenc	e of):						1 week	_
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Graft	versus	1	id to	500 0				2 month	
oʻ	ate be executed thysicien and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence			7600				. /	3
8760,	ate be nysicii he bu	ical		La Kelaps	ed H	odal	cins D	isco-se				tyenrs	
	Attending Physicien: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit	Med	IF FEMALE:			_					1	/	
Box 6	attend attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy	,		1	23d. Date of delive Month	ory Day Year	
P.O.	he de	yslc	1 □Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown	time of death	5 L	Other (specify) _					/	
	that the the the the the the the the the th	/Ph	Part II. Other significant condition	contributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to the	ne cause of death'	?
ds	puires n sign ald be	d by							1 🗆	Yes 2	No 3□Prob	abiy 4 Unkno	own
Records,	w require s been significant	iete			-				24a. Was	an	24b. Were auto	psy findings availa	able
	The Ister Is	Completed	<u></u>							ormed/?	prior to condeath?	npletion of cause	of
ta	ian: 'rtifica	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only	2/2 No one)	1 Yes	2 No	
>	nis ce direc	To B	examiner? 1 ☐ Yes 2 █ Ño	Hospital: 1 X Inpatie	nt 2□ER/C	Dutpatien	t 3 DOA Oth	ar.	- W		6 □Other (Specif	<i>'</i> )	
0	ng Pł fter tł ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b.	. Time of	28c. Injur Wor	v at	28d. Describe				
Sio	uttendi death. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could no				M 1 🗆	Yes 2 □ No					
Division of Vital	lor At after d Direct in by	Certification:	4 Homicide determine	28e. Place of Inju- building, et	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State	d Number or Rura )	l Route Number,	
_	Acspital or 4 hours afte Funeral Dir tely filled in l		29a. Certifier 1X certifying	Physician: To the best	of my knowledg	ge death	occurred at the tin	ne date and place	and due to the	C31100(c)	and manner as of	atad	
2	To the Respital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) Medicel Ex	eminer: On the basis of and manner sta	examination a	and/or inv	estigation, in my o	pinion, death occi	urred at the time,	date and	place, and due to	the cause(s)	
	To the within 2 To the complete	×	29b. Signature and title of certifier	1 1			29c. Licens	e number	Î	29d. Dat	e signed (Month,	Day, Year)	
	$\mathcal{L}$		A	Juny			D	006011	1	1/021	ah 10,5	004	
7	4		30. Name and address of person wh	o completed cause of d	eath (Item 23a	) (Type,	Print)			Farm			
	/ 1		Andrew Armstrone		Johns H	toption	is Hospita	1 600100	Jolfe St	Bult	th 10, 5	21287	
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 1 1	. 437	ar's Signature	-							
DHI	MH 17 Rev 1/20		natil 1 1	2004	w s	1	books						
		1			OF	RIGIN	AL						

State of Maryland / Department of Health and Mental Hygiene  $200 \, \mu$ 07446 For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9 2004 Melvin D. Rauser March 10:00 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Catonsville 934 Vanderwood Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 11, 1927 9. Birthplace (Stete or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 € M 2 □ F 220-18-4605 76 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23 aor 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at Baltimore Maryland Catonsville 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 934 Vanderwood Rd. 21228 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1945— 1 Xyes 2 No If Yes, Give 1947 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1947 1 ☐ Yes 2 TNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Route Sales Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Paul Rauser Catherine Starkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Rauser, wife 934 Vanderwood Rd. Catonsville, MD. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MD Veterans Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 03-12-04 Crownsville, MD. X □ Donation 5 □ Other (Specify) Crownsville 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician SUDDEN 1 minut CARDEAC resulting in death) /Medical Due to (or as a consequence of): **Examiner** ATHERSCLEROS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed HYPERTENSELN and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Completed by Physician/Medical 14 YPERLIDED FMCA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 7 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: # 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCIT 10, 2004 012/14 Bercheza no amlan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OAMETW & BEREIYS 5 MO FREDERFUL RD BALTEMORE SHLTE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 11 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] For Stata Registrar 07667 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Reay /Medical 5, 2004 4c. County of Death MARCH 7:10 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Oct 4, Salisbury Nursing and Rehab Center Salisbury, Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1 □ M 2 🕅 F Hours 88 031-01-9511 Massachusetts Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Wicomico Salisbury Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 London Avenue 21802 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Willard Woodsum Anne Marie Brown ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Reay/daughter 208 London Avenue Salisbury, MD 21802 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☒ Donation 5 ☐ Other (Specify) Funeral Service Licensee State Anatomy Board Baltimore, MD 21201 ector 655 W. Baltimore Street Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mayour week Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Evantmer must be notified at

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Examine burial-transit attending physician and for use as the burial-trar Physician/Medicai as the use the þ signed b d be deta þ Completed page 2 s this certificate Be P After th funeral Certification: Director: /

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

death.

hours after within 24 hours af To the Funeral D

25. Was case referred to medical examiner? 27. Manner of Death

24a. Was an

autopsy performed? Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 1 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

1 Yes 2 No

1 Natural

2 Accident

3 Suicide

29a. Certifie

Medical

4 Homicide

D70853

29d. Date signed, (Month, Day, Year) 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

my

Hospital:

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

Charles B. Silva, Jr. 31. Date filed (Month, Day, Year)

1346 S. Division St. Suite, Salisbury, Md. 21804

State Registrar

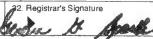
MAR 1 1 2004

al Krey

5 Pending

investigation

6 Could not be determined



2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

			•	For State Registrar	State of Marylar		ent of Health and ate of Death		ne 2004	07448
	,	nysicia Medic	al .	1. Decedent's Name (First, Middle, Last	HANNON	4h C	city. Town, or Location of Dea	2. Date of Death Month	Day Year A 4c. County of Death	3. Time of Death
	1	xamino neral		4a. Facility Name (If not institution, give  Seph RHChie  5. Social Seturity Number  6. Se	/	last birthday) If Un	BOHIMORU der i Year If Under 24 Hrs	8. Date of Birth	NIE	place (State or Foreign intry)
	- Q	ector		Usual Residence of Decedent  10a. State  10b. County	• 02	Yrs. ty, Town or Location		12-07-	51	10d. Inside City Limits
	death with the Maryland	e retilied	Director	10e. Street and Number		Edgeme	Zip Code	10g.	Citizen of What Cou	1   Yes 2   No
	, i	As a free fourth be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1   Yes 2   Yoo		ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puel	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
	21215-0036 d within 72 hours after giene.	olical Exer	eted by I	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad	Year or Dates:	1 ☐ Ye	Jsual Occupation  f work done during most of wo	nrking 16b	Specify: B. Kind of Business/Ir	IACK Industry
	Hygin N	avent, the Mu	e Completed	Elementary/Secondary (0-12)  2+0 CRADO  17. Father's Name (First, Middle, Last)	2 YRS	AR-	18. Mother's Na	me (First, Middle, Maid	YHISTRY Jen Sumame)	
Do	arylar should be	traumatic av	ToB	Teddy Shannon  19a. Inform 's Name/Relationship (7)	UR. ype, Print)	19b. Mailing A	ress (Street and Number or	S THUM!	QSON ty or Town, State, Zi	ip Code)
٥٠	Heal	other		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	Place of Disposition (cometery, crematory	Name of or other place)	Date 20c.	Cocation City or T	Own, State
3/4/04	Baltimore, permit. Pages 1 a Department of Hea	any injury or one		21. Signature of Funeral Service Licens	See A	8728	e and Address of Facility Wo	ughn C.Gr Kandalk	eene Fur Stown, I	neral Service ND 21122
•	Phys			23a. Part1. Enter the dispase, or comp shock, or heart fail tri. List only of Immediate Cause (Final disease or condition resulting in death)	dications that caused the deal one cause on each line.	static	mode of dying, such as cardia			Approximate Interval Between Onset and Death MOINTUS
27 TRED	Exar	dical niner	er	Sequentially introductions if any leading to immediate	b. Due to (or as a consec			,		
1 1 1	760, te be executed	nysician and he burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):			N.	
	Box 687	ls t	n/Medical	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome of pregn				23d. Date of deliv	/ery
0	O. \$	ached	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of 6 9 ☐ Unknown	death 5 ☐ Other			Month	Day Year
	Records,	p e d	by	Part II. Other significant conditions of	1 (2)	1	ng cause given in Part I.	1 ☐ Yes	2□No 3×Pro	bably 4 Unknown
52	ital Rec	certificate has rector, page 2 a	e Completed	Hepatitis  25. Was case referred to medical			26. Place of De	autopsy performed 1 Yes 2 2	prior to co death? No 1 \( \subseteq Yes	opsy findings available ompletion of cause of
2	Phys	al di	n; To B	27. Manner of Death	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	ER/Outpatient 3	DOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Residence		in Hospice
M	isic Iten death	Director: After In by the funer	rtificatio	1  Accident		M nome, farm, street, fac	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St		ral Route Number,
2×	Div To the Hospital or A within 24 hours after	to the Funeral Direct completely filled in by	Medical Certification:	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	ysician: To the best of my kn ilner: On the basis of examin and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and place	e, and due to the cause urred at the time, date	a(s) and manner as and place, and due	stated. to the cause(s)
•	To th within	to to to	Me	29b. Signature and title of certifier	D		29c. License number D 2417		Date signed (Month,	
		9		30. Name and address of person who	Lichey Hosp	nice 838	D 2417	St Ball	imore M	10 21201
		Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				

		Flease	State of Manda				-	_	ie.	
		1 - State	State of Marylai		tificate of			200	04 071	. 1. 0
		1. Decedent's Name (First, Middle, Las	st)		incate of	Dealli	2. Date of Deat		3. Time o	Death
Physi		A11	bodra				Month	Day 30	Year Olli	
Exam	dical iner	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deatl		4c. County of		
		Sinai Hospital	Sf Bathmon	e	Baltim	one		N	14	
Funera		5. Social Security Number 6. S	ex 7. Age ( <i>In yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth Month, Day,	Year)	Birthplace (State of Country)	or Foreign
Directo	r	Usual Residence of Decedent	13	TTS.			UCT.3,	1990		ind
yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation	-			10d. Inside C	ity Limits
a-fall	ctor	Maryland NI	A   1	Balt	imore	2			1 XYes	2 □ No
를 다. 8 c 28	Oire	10e. Street and Number	11 01		10f. Zip Code	A :	10	g. Citizen of Wh	nat Country?	
e 23e	Funeral Director	2920 Gran	Tley Rd		alla	215		US	>#	
ter de	-ru	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No	J.S. 13. V	Was Decedent of f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.	
Urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 21 No	Specify:		Specify:	Rlack	1
d 21215-0036 filed within 72 hours after death with the Maryland tygiane. tygiane. then "natural", or Itame 23a or 28a-1 ahow ont, the Medical Examination that be notified at	Completed by	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occu	pation during most of wor	kina	6b. Kind of Busi	ness/Industry	
Marin Paris	mpfe	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)	9	01	1	
Hygia thert	ပိ	17. Father's Name (First, Middle, Last)	0	5	Tuaei	18 Mother's Nan	ne (First, Middle, N	Scr (aiden Sumame)	1001	
antal ked o	To Be	Francisco	Sahadi	CA		Shail	a Ton	2 C C 7	couln	
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiane. 7 ie marked other than "natural", or traumatic event, the Medical Exam	-	19a. Informant's Name/Relationship (7	ype, Print) (Parents)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number,	City or Town, St	ate, Zip Code)	
and 2 and 2 balth a n 27 is		Mr. + Mrs. Franc	isco Sabeda	a 24	120 6	arant1	ev Rd	Bala	to. Md. 2	1218
of He		20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐		Place of Disportemental Place of Disportery, crem	sition (Name of natory or opher pla	ce) \\ \( \) \\ \( \)	Date 2	Oc. Location - Ci	ty or Town, State	-
Pages Iment of I		*4 □Donation 5 □ Other (Specify	Ki	ng M.	em. Par	K 3/13	12004	Balto	. Md.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 ie marked other than "natural", or Itame 23e or 28e-1 ahow any injury or other traumatic event, the Medical Examinat must be notified at	i i	21. Signature of Funeral Service Vicen	see / /	22	Name and Address	ess of Facility	S Fune	eral t	tome	
		23a Part 1 Hoter the disease or comm	plications that caused the dea	122	1.11 222	Vorth /	tue 6	Salto.	Md. 21 Approximate	216
		23a. Part1 Inter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	, (7)	6	-			Interval Bet	ween
Physician /Medica		disease or condition resulting in death)	a. Systemic  Due to (or as a consec		mmatcry	Kespone	Syndr	one	IIda	YS_
Examine	r		hemasaha		shock				12 des	15
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec		31 00				12000	10
and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· tollicular		Intic	cell so	ercoma	No.	3 mont	ts_
Box 68760,  and certificate be executed attending physician and for use as the burial-transit	cal Ex	lesulting in death) Last	Due to (or as a consec	quence of):						
687 ificate g physias the			d							
Certification	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn.					23d. Date of	of delivery	
O. BOX he death cer the attendin	iciar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c		Ectopic pregnanc Other (specify) _	y 		Month		rear .
P.O.	hys	9 Unknown	9□ Unknown							
	by F	Part II. Other significant conditions co	ontributing to death but not res	sulting in the un	derlying cause giv	en in Part I.			ute to the cause of d	
VItal Records,  vician: The law requires ti certificate has been signe rector, page 2 should be or	Completed						1 Tes	2 12 No 3 [	□ Probably 4 □U	Inknown
Rec	nple						24a. Was an autopsy	prio	re autopsy findings a or to completion of ca	available ause of
VITAL F vicion: Th certificate rector, pag							1 Ves 2	ed? dea □ No 1 □	Yes 2 No	
t Vital Re lyoician: The lis certificate hadirector, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	158/0	all post of	THE RESERVE OF THE PARTY OF THE	th Check on one			-
g Physer this eral dia	<b> -</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3□ DOA 28c. Injui	4   Nursing Ho	ome 5 Resider		(Specify)	202
ISION Mtending death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		'k? Yes 2 □ No				
DIVISION Of all or Attending Physatter death. I Director: After this d in by the funeral d	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,		or Rural Route Numi	ber,
Urs af			1							
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	/sician: To the best of my knoiner: On the basis of examina and manner stated.	owledge, death ition and/or inv	occurred at the tile estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manne e and place, and	er as stated. I due to the cause(s)	)
Fo the within Fo the	Me	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed (A	Month, Dey, Year)	
, F 0		I Clam ( &	celietic mo		D38	127	N	ranch	7, 20131	
2		30. Name and address of person who o							.,	
4		Haron Zuckerb			pital	BALTIMO	RE, MAG	LYLAND	21215	
S	tate trar	31. Date filed (Month, Day, Year)  MAR 1 1 200	32¢Registrar's Signa	iture						

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of W	aryiaii				Death	i wientai riy	Reg. No		071	E 0
			1. Decedent's Name (First, Middle, La.	st)						2. Dete of De Month	eth De	V Year	3. Time of	Dealth
	Physician		Robin Arcl	her Si	nives					March		004	11:30	AM
-	/Medica Examine		4a Fecility Name (If not institution, giv					4	b. City, Town, o	r Location of Deet		County of Dec		
	27/311110		1543 Grays Ford	Road					Odento	n	A	nne Arı	ınde 1	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	lest birthdey)	If Under Months	1 Year Days	If Under 24 Hi Hours Mi	rs. 8. Date of Bir			thplece (State of ountry)	r Foreign
	Director		212-96-7647 Usuel Residence of Decedent	□M 2 <b>X</b> F	39	Yrs.	MONUTS	Days	Hours Mi	March			ryland	
	aryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside Cit	,
	with the Marylan a or 28a-f ehow	Director	Maryland Anne Art	unde1			enton 10f. Zip				10a. Cit	izen of Whet C	1 ☐ Yes	2 X 140
	23a or	2	Section 1975	Doga					21113		-	ited St		
	ne 2	<u>e</u>	1543 Grays Ford 1	12. Was Decedent	Ever in U,	,S. 13. \	Was Deced			(Specify Yes or No erto Rican, etc.)		14. Race - Am	erican Indian,	
336		by runeral	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2  If Yes, Give Yeer or Detes:			fYes,spec 1⊡Yes 2		Specify:	erto Rican, etc.)		Black, Wh	ite, etc. White	
ŏ	natural,	2	15. Decedent's Ed			16a. Deced	lent's Usua	l Occup	ation	STATE OF	16b. K	ind of Business		
21215-0036	- 4	Be Completed by	(Specify only highest gre	completed) College (1-4or	5+)				during most of w			• • • •		
9	2 should be filled within and Mental Hyglene. Is marked other than sumatic event, the M	5	12th 17. Father's Neme (First, Middle, Last)			Huma	n kes	ourc		<u>ralist</u> ame <i>(First, Middl</i> e		uilent Sumame)		
Maryland	Hental Ked o	0	Earl R.	Archer,	Jr.				Linda	Fay	e	Howe]	.1	
ary	and N and N ie mar	_	19a. informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	(Street	end Number or I	Rural Route Numb	er, City o	or Town, State,	Zip Code)	
	od 2 27 is		Robert B. Shives	/ Husband		1543	Grays	For	d Road	Odenton	, Ma	ryland	21113	
ē,	of Had		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nem	ne of ther plea	e)	Date	20c. Lo	ocation - City o	Town, State	
Ë	it. Page intment or intent: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification 5 ☐ Other (Specification )	JRemoval from State y)		t Arun				3/9/04	0de	nton. M	iaryland	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any injury or other treumstic event, the Monce.	r	21. Signature of Funeral Service Licen	isee		22	. Name en	d Addres	ss of Facility	Home &				
<u>m</u>	897	-	Quanta R	Thomas	_ MOO					ad Odent				
			23a. Part 1 Enter the diseese, or com- shock or heart failure. List only		d the deat	h. Do not ent	er the mode	e of dyin	g, such as cardi	ac or respiratory a	rrest,	in Ly Lui	Approximate Interval Bety	9
	Physician		griddings riduit fallaid. Eldt ding	3.10 04400 0.11 0401.1	10	1	21		/	/			Onset and D	
4	/Medical Examiner		Immediate Ceuse (Final disease or condition	a. /	"Le	+dal	late	0	Lley (	elnes	~		7 m	ds.
\ <sub>1</sub>			resulting in death)		Due to (o	or es e conseq	uence of):	0						
	petr list	edical Examiner		b	Due to /e								1	
oʻ	ficate be executed 9 physician and 1s tha burial-transit	Z Z	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events		Due to (o	r es e conseq	uerice or):						 	
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	- C 0 0 -		resulting in death) cast										I I	
Вох	th ca thend or us	2	_	d									1	
	e day	35	Part II. Other significant conditions of	ontributing to death I	out not res	ulting in the ur	nderlying ca	ause giv	en in Part I.	23b. DId	tobacco	use contribut	e to tha cause o	f death?
P.0	The law raquiras that the daath car sate has bean signed by the attendin page 2 should be detached for use									12	Yes 2	□ No 3□F	Probably 4 🗆 t	Jnknown
rds	n sign	2								24a. Was	an autop	osy 24b.	Were autopsy fi available prior to	ndings
Records,	s bea	ble								perio	iiiieu :		completion of ca of deeth?	ause
Ä	ysician: The law lis cartificate has t director, page 2 s	Ę								1 🗆	Yes 2	DNo	1 □ Yes 2 2	No
Vital	artifice sctor,		25. Was case referred to medical examiner?							eeth (Check only	000)			
of V	Physician: this cartific ral director,	2	1 Yes 2 No	Hospital: 1   Inpati	ent 2	ER/Outpatien			4 U Nursing	Home 5 / Resi	dence	6 □Other (Sp	ecity)	
ב	fler thunera		27. Manner of Death 1 DNeturel 5 □ Pending	28a. Date of Inju	ıry ay Year)	28b. Time of Injury		8c. Injun Worl		28d. Describe	how injui	y occurred		
sio	Attending ir death. ector: Afte by the fune		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		Yes 2□No	004 1	C44	144 - 5 5		
Division	tal or Attending Pirs after death.  al Director: After tiled in by the funera		4 Homicide determined	28e. Plece of In building, e	lc. (Specify	ome, tarm, str y)	eet, factory	, oπice		City or To	wn, Stete	)	lurel Route Numi	<i>∋er</i> ,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Macallos Completed Comp	edical	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of end manner si	f examinal	wledge, death tion end/or inv	occurred e	et the tim	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner a I place, and du	s steted. e to the cause(s)	)
	of the of the omple		29b. Signeture and title of certifier	Junamen S	2		29c	. Licens	e number		29d. Dat	te signed (Mon	th, Dey, Year)	
	- 5 - ô		1//		12	, /		6)	315	5-)	Ma	roh	Prox	14
7		$\mathbf{I}$	30. Name end address of person who	completed cause of	Meth (Item	23e) (Type,	Print)	1	1		7	10	7	1
_	Ce		Olussel Miller	Juan 3	05	4.051	0,40	4 1	Urvy.	Ofent	MAY	1, 16	1. 2/04	5/
	State Registra		31. Dete filed (Month, Day, Year)	32 Regist	rer's Signa	ture	retes		J			,		/

DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 25, 2004 8:00 AM M Shirley M. Sullivan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Talbot 640 Mecklenburg Avenue #224 Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F 217-24-6606 73 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Talbot 1 ☐ Yes 2√ No Director Easton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 640 Mecklenburg Avenue #224 or Items 23a 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ Specify: Specify: white 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, tha Me Elementary/Secondary (0-12) College (1-4or 5+) assembler factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Edward Sweeney Pauline Marie Conn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Shiflet/daughter 208 Stewart Avenue Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 \ Donation 5 \ Other (Specify) 21. Sign hard of Euneral Service Licensee Rona Lt S. Wade Di State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 12 months cell **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death ō in the past 12 months? Month Year Day 5 Other (specify) signed by the aid be detached for 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Déath 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. м investigation 2 Accident To the Hospital or Attended within 24 hours after dealf To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 3/04 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Drive Suite 5, Easton, mo 21601 David Smith 38. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 29, 1:45 PM Trudy Lee Shackelford 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 811 Matthews Avenue Harford Abingdon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 9, 1947 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖺 F 56 217-50-6779 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Harford Aberdeen Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 811 matthews Avenue 21001 permit. Pages 1 and 2 should be tiled within 72 hours atter death a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or Hems 23e eny injury or other traumatic event, the Medical Ferror 200. USA Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) federal worker U.S. government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Owen Shackelford Sr Georgia Juanita Nichols ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Shackelford/brother 1012 Leeswood Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 Other (Specify) 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** pulmonar Cardio /Medical Due to (or as a consequence of) 4 months **Examiner** Pan Creas Carcinema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Careinomatosis Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Signature and title of certifier 29c. License number 29d) Date signed (Month, Day, Year) 29b. 31512004 22105 DIDOL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M · s. BAC

State Registrar 2401

31. Date filed (Month, Day, Year) MAR 1 1

W. Belvedere

VR

2. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

the Maryland

TIMOVE

MARYLAND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 07453 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 2, 2004 **Physician** Maurice Jacob Sarason 8:15 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Laurelwood Care Center E1kton Ceci1 If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 82 Yrs 042-07-3752 Apr 20, 1921 Director Connecticut Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f ahow any Injury or other traumatic avances. 10a State 10c. City, Town or Location 10d. Inside City Limits MD Cecil Port Deposit 1 ☐ Yes 2X No Funeral Director 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 128 South Main Street 21904 12. Was Decedent Ever in U,S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Detes: 140-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fort Dupont contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Lucy Benwell Slater Maurice Mayer Sarasohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 128 South Main Street Port Deposit, MD 21904 Norma Sarason/spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronalli S. Wade, Virector 22. Name and Address of Fecility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner WELKINSON ? DISCOSE anding physician and usa as the bunal-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 should Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To th st Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not determine 3 Suicide 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier dipliner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) 30. Name and eddr s o n Newlysus DE 19720 7 CHRECHMANS STURE Hen

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 1 2004

Registrer's Signeture

			For State Registrar	State of Ma	aryland			f Health	and M	ental Hy		•	07454
	Physici /Medio	cal	1. Decedent's Name (First, Middle,	IM S.	HEA	ARE.		TR		2. Date of Do Month MARC	H Day	2004	3. Time of Death  10:00 A M
7	Examir	ier	4a. Fecility Name (If not institution, 765/BEK)  5. Social Security Number	ey DRIC	E (In yrs. las	of hirthday)	4b. City, Town	SADE	of Death	S. Data of Bi	A	JUE J	FRUNDEL
	Funeral Director		216-18-1539 Usual Residence of Decedent	1XXM 2□F	78	Yrs.	Months Da			8. Date of Bi (Month, Di SEPT 14			place (State or Foreign ntry) ND, MD
	Maryland	tor	10a. State 10b. County MARYLAND ANNE	ARUNDEL		Town or Loc ADENA	ation	_				1	10d. Inside City Limits 1 ☐ Yes 🌋 🖾 No
2	death with the ms 23a or 28a r mail te not	ai Dire	10e. Street and Number 7651 BERRY DRIVE				10f. Zip Cod				-	of What Coul	ntry?
lean 036	ē = =	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married	12. Was Decedent B Armed Forces? d 1 VYes 2 N If Yes, Give Year or Dates:		1	as Decedent Yes, specify C □ Yes 💥			city Yes or No Rican, etc.)	İ	Race - Americ Black, White, pecify: WH	
Mille 21215-0036	n 72 ho	mpleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5		(Give k life. D	ent's Usual Oc ind of work do O NDT use re DRIVER	ne durina mo	ost of workin	ng	16b. Kind	of Business/In	
Maryland 2		To Be Co	11 17. Father's Name (First, Middle, La WILLIAM SHEARER, S			IROCK	DRIVER	18. Moth		(First, Middle			CARRIERS
	and 2 should salth and Men n 27 is marks er traumatic		19a. Informant's Name/Relationship PEARL ATKENS SHEAF				Address (Str					own, State, Zip	) Code)
Thea altimore.	permit. Pages 1 al Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition  1 ∰Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Line)	cify)	сел	netery, cremi	ition <i>(Name of</i> atory or other ; MEMORA I L	place)		ate )04		ion - City or To	own, State  MARYLAND
8760.	Physician /Medical Examiner points it and points it are points it and points it and points it and points it and po	dical Examiner	Kelly Gree  23a. Part1. Enler the dis ass, or or shock, if heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	the death. e.  a consequent	Do not enter						TITLE,	Approximate Interval Between Onset and Death
P.O. Box 68	the death certificat y the attending phy ched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal de	eath 3 🗆 🛭	etopic pregna Other (specify)				23d.	Date of delive	ery Day Year
	v requires that the de been signed by the a should be detached	by	Part II. Other significant condition	s contributing to death bu	it not resulti	ng in the und	derlying cause	given in Part	l.	23e. Did t			ne cause of death?
al Reco	Physician: The law re this certificate has ber al director, page 2 sho	Completed								24a. Was autoj perfo 1  Yes	psy prmed?	prior to cor death?	psy findings available mpletion of cause of
Division of Vital Records,	ding Physician: h. After this certific funeral director,	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1. Natural 5 Pending investigal	Hospital: 1 Inpatier  28a. Date of Injur (Month, Day	v 28	VOutpatient Bb. Time of Injury	28c. Ir	Other	lursing Hom	(Check only only on the State of A Resident	dence 6	Other (Specify	<i>ı</i> )
Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigat 3 Suicide 6 Could no determina	be Oss Blace of lain	ry - Al home . <i>(Specify)</i>	e, farm, stree				8f. Location ( City or To	Street and Ni wn, State)	umber or Rura	I Route Number,
/*	the Hospital nin 24 hours a the Funeral i	Medical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination	edge, death on and/or inve	occurred at the stigation, in m	e time, date a ly opinion, de	nd place, ar ath occurre	nd due to the d at the time,	cause(s) and date and pla	I manner as st ce, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1/10	>/	7	29c. Lice	ense number	(7)		29d. Date sig	gned (Month, I	Day, Year)
_	4X/		30. Nam nd ddress of person wh	completed cause of de	eath (Item 23	3a) (Type, P	rint)	ed no	1 19cm	Flend	Shran	rul-7	106)
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 1 2004	# Registra	r's Signatur	Monage .	5	1.30=(1)		Sings-rock	To the second		7

John Coar Scarborough
Baltimore, Maryland 21215-0036

		1 - For State Registrar	State of Marylan	-	tificate of			Reg. No.	U U U	0745
		1. Decedent's Name (First, Middle, Las	st)				2. Date of De Month	ath Dey	Year	3. Time of Death
Physici /Medic	A 2788	John Oscar Sc	arborough, II	L			March	1 3,2	2004	9.30 P
Examir	ner	4a. Fecility Name (If not institution, give	tam llocai	101	4b. City, Town, o	Location of Dea	th		nty of Deeth	
		5. Social Security Number 6. So	9x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	8. Date of Bir	th	9. Birthp	lece (State or Fore
Funeral Director		217-22-3566 X	76 76	Yrs.	Months Days	Hours Min	. (Month, Da		Coun	ID
* **		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1:	0d. Inside City Lim
naturel', or Items 23a or 28a-f show dical Examinar must by notified at	ţō	MD Balti	imore	Towso	n					1 ☐ Yes 🎾
r 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
23a C	alD	15 Treeway Ct. A	Npt. 1C			21286		US	SA	
ems in	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of h Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. R	Race - Americ Black, White,	
l o .	by Fu	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 √2 Yes 2 □ No If Yes, Give Year or Dates: 45 – 4	7	☐ Yes 2 <b>∑</b> No	Specify:		Spe	c <i>ity</i> : wh	nite
le le le le le le le le le le le le le l	ed t	15. Decedent's Ed		16a. Deced	ent's Usual Occup	pation		16b. Kind of	Business/Inc	dustry
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other than	E O	Lielinemary/Geodicary (o 12)	5+	Teac	her				ation	
	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sum	name)	
	၉	John Oscar Scarb		401 14 10		Paline 1		Cit T	- Chan Zi-	Codel
E 60 E		19a. Informant's Name/Relationship (					rura/Route Numbe			Code)
f Health item 27 other tra		John V. Scarboro  20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Towson,	MD 21 20c. Locatio	n - City or To	wn, Stete
nt of t: # it		1 Burial 21 Cremation 3 4 Donation 5 Other (Specify	Hemoval from State		natory or other pla	1	112/04	1	ME	
Department of the function of		21. Signature of Funeral Service Licen		22	Name and Addre				el, MC	
Depa Impo eny i		Michael J. Ela	agle	Le 1	emmon F	uneral H	ome of [ ., Timor	Dulane	y Valle	ey, Inc.
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat	th. Do not ente	er the mode of dyi	ng, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition		MIMA	ir with	moti	ast asi			Onset and Death
Medical		resulting in death)	Due to (or as a consec		VVII	1 1/16 13	171 4213	>		1
kaminer			V )							
		Sequentially list conditions.	b. Pulmona	ry To	xicity					10 day
ŧ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Pulmona a consecutive bull to (or as a consecutive bull)	quence of):	xicity					10 day
and I-transit	xaminer	if any, leading to immediate	с		xicity					10 day
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DHMH 17 Rev 1/2001

State Registrar

Physi	cian	State of Maryland / De State of Maryland / De	epartment of Health and Control of Health	2. Date of Death	3. Time of Death
/Med Exam	lical	Fffie Edmona Simmons  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	March 8 200	Pay Year 10:30 am M
		7721 Daniels Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Baltimore		Baltimore City
Funera Directo		216 22 6350 1 1 M 2 F 88 Yrs	Months Days Hours Mir		9. Birthplace (State or Foreign Country) Elkins, W.
Aaryland I show	ō	10a. State 10b. County 10c. City, Town of			10d. Inside City Limits
h with the h 23a or 28a-	al Director	Maryland Baltimore City Baltimore 10e. Street and Number 7721 Daniels Avenue	10f. Zip Code 21234	10g.	1 Yes 2 No Citizen of What Country?
-0036 hours after death with the Maryland tural; or Items 23s or 28s-1 show at Exerciting the regulised at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give 1 Vidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 10 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 XNo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
15- in 72 n na	Completed	15. Decedent's Education (Specify only highest grade completed) (CElementary/Secondary (0·12) College (1·4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired)	orking	. Kind of Business/Industry
land 212 Id be filed with ental Hygiene kad other tha	o Be Co	17. Father's Name (First, Middle, Last)  Michael Mylins - Michael Mylius	maker  18. Mother's Na Florence	me (First, Middle, Maid	usekeeping-Own Home
lore, Maryland 2 ges 1 and 2 should be liled t of Health and Mental Hyg If Itam 27 is markad othe or other traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or R Daniels Avenue Baltin	ural Route Number, Cit	
E a a a a a		20a Method of Disposition 20b Place of Di	sposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Baltim permit. Pa Departmen important: any injury once.		21. So pature of Funeral Service Licensee	22. Name and Address of Facility Lassahn Funeral Home Ii 7401 Belair Road Baltin	r	
https://www.html.com/physician and physician and physician and state the burial-transit		23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate
The law requires that the death certificate be ex the has been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medical		3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
w requires the	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
VICAL RECORD sician: The law requir centificate has been si irector, page 2 should I	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
ding Phy h. After this funeral d	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat  27. Mannar of Death	ient 3 DOA Other: 4 Nursing F	ath (Check only one) Home Residence 28d. Describe how in	
tal or Attandi	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, de additional examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurrence.	o, and due to the cause( irred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
P M P M	Σ	29b. Signature and title of continue	29c. License number 46		mold 8, 2004
Ψ		30 Name and address of person who camples to ause of death (Item 23a) (Two Death (Item 23a) (Two Death (Item 23a) (Two Death (Item 23a) (Two Death (Item 23a))	5. Print) 5629 LONG	Convon R	molt, 8, 2004
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	445		2116/

		1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>		Health a		_		
Physici /Medic		1. Decedent's Name (First, Middle, La EVANGELIN	E SMYR	RNIOUDIS			2. Date of De Month		3. Time of Death	
Examin	er	4a. Facility Name (If not institution, giv Gilchrist Cente  5. Social Security Number 6. S	er	nber) 7. Age (In yrs. last birthday		son			ltimore	
Funeral Director			□ M 2 <b>XX</b>	74 Yrs.	Months Day		8. Date of Bir Min. (Month, Da May 7,	1929	Birthplace (State or Foreign Country)     Maryland	
5-0036 72 hours after death with the Maryland natural; or items 23a or 28a-f show alea! Exeminat be notified at	Funeral Director	Maryland Baltimon  10e. Street and Number  205 East Joppa Roa  11. Marital Status	ad	TOWSON	10f. Zip Code 212	86	sig2 (Cassity Vacanty)	10g. Citizen of W USA		
5-0036 72 hours after de natural', or items often Exertire re	þ	1 Never Married XX Married	Armed For 1  Yes If Yes, Give Year or Da	ces? 2/LXNo etes:	1□Yes XXN	o Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)	Specify:	- American Indian, K, White, etc. White	
121 within ene.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		4or 5+) (Give	dent's Usual Occ kind of work don DO NOT use retii Homemake	e during mos red)	t of working	16b. Kind of Bu	iness/Industry Home	
be file d oth	To Be	17. Father's Name (First, Middle, Last) Nicholas Matthew				Cre	er's Name <i>(First, Middl</i> e SSA Lallas	Maiden Sumame	9)	
		19a. Informant's Name/Relationship ( Nicholas T Smyrnic 20a. Method of Disposition			East Jop	pa Roa	d Towson, M	laryland		
Baltimore, permit. Pages 1a Department of Her important: If item any injury or other once.		V Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of Funeral Service Liber Community)		Greek Ortho	odox Cemete	ery ress of Facilit	3/12/04 Mitchell-Wi York Road Bal	Baltimo edefeld Fu	re, Maryland neral Home Inc.	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that ca one cause on ea a.  Due to (c	netastati		ing, such as	cardiac or respiratory a		Approximate Interval Between Onset and brath Illuming	
8760, cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	or as a consequence of):  or as a consequence of):						
cords, P.O. Box 68 wrequires that the death certifica been signed by the attending ph should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	1 Live bir	nt at time of death 5	Ectopic pregnan Other (specify)	су		23d. Date of delivery  Month Day Year		
I Records, P.O. The law requires that the ate been signed by the bage 2 should be detached.		Part II. Other significant conditions of	ontributing to dea	ath but not resulting in the u	nderlying cause g	iven in Part I.	101	es 2 0 3	oute to the cause of death?  B Probably 4 Unknown	
I Re The la ate has page 2	Be Completed	25. Was case referred to medical				26. Place	24a. Was autop performed 1 Yes	rmed? de 2 No 1	ere autopsy findings available or to completion of cause of ath?  Yes 2 No	
on of ling Phys After this funeral di	Certification; To E	examiner?  1	28a. Date of (Month) 28e. Place of	patient 2 ER/Outpatier Injury , Day Year)  28b. Time o Injury of Injury - At home, farm, str g, etc. (Specify)	28c. Inju	ther: 4 Number N	rsing Home 5 Residence Residence Page 1986. Describe h	lence 6 M And Number	d or Rural Route Number,	
25 5 60 00	Medicai C	29a. Certifier Check only 2 Medical Examone)  29b. Signature and title of certifier	vsician: To the biner: On the bas	pest of my knowledge, death	vestigation, in my	opinion, deat	h occurred at the time, o	date and place, and 29d. Date signed	(Month, Day, Year)	
Sta	te.	30. Name and address of erron who of the William St. Date filed (Month, Day Year)	11 i am	of death (Item 23a) (Type, 660)		97		3-100 owson, Ma	nryland 21204	
Registra DHMH 17 Rev 1/20	ar	MAR 1 1 2	004	Server & ORIGIN	Apar.	4				

Smyrnioudis, Evangeline Holoy 1: 20Am

			1 - For State Registrar	State of Ma			ent of H		nd Mental	Hygiene Reg. No		با (	07458
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)	. St	urm	)	City, Town, or		2. Date of Month	Death Da		04	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sec	rtation an	(In yrs. last birth	led J	Dalt1	MO C	Hrs. 8 Date o	f Birth	9.	N/A Birthplac Country	e (State or Foreign Land
	D	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A		10c. City, Town	or Location			1107.		. 722 1		. Inside City Limits 1 X Yes 2 □ No
	ath with the s 23s or 28s	rai Director	10e. Street and Number 406 Winston Avenu				. Zip Code	212		10g. Cit	izen of What		?
9036	hours after death with the Maryland tural; or Items 23a or 28a-1 show al Exercit set must be restitled at	d by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ender Armed Forces?  1 XYes 2 □ Note of Yes, Give Year or Dates: 1				spanic Origir n, Mexican, I Specify:	n? (Specify Yes o Puerto Rican, etc.	No-	14. Race - A Black, W Specify:		
Maryland 21215-0036	within 72 ene. than nai	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(	Give kind o life. DO NO	Usual Occupa f work done d T use retired) SICIAN	uring most o	3	16b. Ki	ind of Busine		try
aryland	2 should be filed and Mental Hygi is marked other aumatic event. I	To Be	17. Father's Name (First, Middle, Last) Hubert Jerome  19a. Informant's Name/Relationship (Ty)	Sturm	19b. i	Mailing Add		Eliz	s Name (First, Mic abeth or Rural Route Nu	Johanr	na S	tall	
	d Ting		Merle Sturm  20a. Method of Disposition  1 X Burial 2 Cremation 3 Re	(Wife)	20b. Place of E cemetery,	Wins Disposition ( crematory	ton Av Name of or other place	enue	Baltimon Date	ce, Ma	ryland	212 or Town,	212 , Stete
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	an		22 Name Mit 0 6500	heii-v York	viedef Road	eld Fune Baltimo	ral Ho re, Ma	me Tr	20	Maryland 212
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Alzh	he death. Do no	r's 6	1)	, such as ca		y arrest,		Int	pproximate terval Between inset and Death
8/60,	. 7,03	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause, (Disease or injury that initiated events resulting in death) Last		consequence of)								
.U. BOX 68/	ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ac. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetel death	3 □Ectopi 5 □ Other	c pregnancy (specify)			_ 2	3d. Date of d	lelivery Day	y Year
cords, r	w requires that the dibeen signed by the should be detached	þ	Part II. Other significant conditions cont	tributing to death but	not resulting in th	he underlyir	ig cause giver	n in Part I.		id tobacco us		to the ca	ause of death?
T T	The lay ate has page 2	e Completed	25. Was case referred to medical					OS Blace of	24a. W au pe 1  Ye	itopsy enformed? s 20 No	24b. Were prior to death?	comple	findings available ation of cause of
5	Phy ral d	ation: To B	examiner? 1  Yes 2 No Ho  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1  Inpatient 28a. Date of Injury (Month, Day )		ne of	DOA Other 28c. Injury a Work?	4 Nursir	ng Home 5 R			ecify)	
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify)				City or	Town, State)	l Number or l		
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1. Vertifying Physi 2 ☐ Medicel Exemine 29b. Signal de 1 d title of certifier	cien: To the best of r er: On the basis of ex and manner state	kamination and/c	or investigat	ion, in my opir	nion, death c	occurred at the tim	e, date and	place, and du	e to the	cause(s)
	di		30. Name and address of person we com	inpleted cause of leaf	th (Item 23a) (Ty	rpe, Print)	D037	070 00 Los	ch Raven Cerre	Mar	ch 1	Balt	I More,
	Stat Registra		31. Date filed (Month, Day, Year)  MAR 1 1 20	32. Registrar's	Signature	6	Spark	2	Cirel	-CH	pulaga.	10.	21213

			1 - For State Registrar	State of Maryla			lealth and			0745
H	Physic /Medi		Decedent's Name (First, Middle, Lass     Edward Alexan	•				2. Date of Death Month March 9.	Day Yeer 2004	3. Time of Death 7:30 AM
e e	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat		4c. County of Deeth	
À	Funeral Director		5. Social Security Number 6. St 018–18–1047	7. Age (In yr	s. last birthday, 9 Yrs.				(ear) 9. Birthpl	lece (State or Foreign try) achusetts
	show	٦	Usual Residence of Decedent  10a. State 10b. County		City, Town or L				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ № 0
	with the N or 28e-f	Directo	Maryland Harfor		Bel	10f. Zip Code		10g	. Citizen of What Coun	
	s 23	rai	209 E. Heather			210			USA	
136	72 hours after death with the Maryland natural', or items 23a or 28e-f show dired Examiner was be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  Marmed Forces?  Marmed Forces?  No If Yes. Give Year or Dates: 194		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White, a Specify:	etc.
15-0036	I within 72 hours iiene r than "natural", the Wedical Ex	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	ident's Usual Occup is kind of work done DO NOT use retired	during most of wor	rking 16	b. Kind of Business/Ind	Mite Justry
717	filed within Hygiene. other than "		Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	College (1-4or 5+)		onstructi	on Estim		Steel Manuf	acturer
Maryland	should be find Mental Himarked of	To Be	Arthur Hayden S				Marybe		Catto	
	d2 thau		19a. Informant's Name/Relationship (7)  Eileen L. Shattuc						ity or Town, State, Zip Maryland 21	
more	Pages 1 an ent of Heali nt: If item 2 ry or other		20a. Method of Disposition  1 □ Burial 2 ②Cremation 3 □  4 □ Donation 5 □ Other (Specify	20b.	Place of Dispo cemetery, crei	osition (Name of matory or other place Service C	(e)	Date 200	c. Location - City or Tov DWSOn, Mary	vn, State
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Sanutur of Funeral Service Liften		1 22	McComas F	uneral H	ome, P.A.	don, Maryla	
,007	Centificate be executed ding physician and ding physician and see as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d.	quence of):	na g	jan	nease		Onset and Death
.O. BOX 00	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes > 1 ☐	23c. If yes, outcome of pregr 1	al death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	y Day Year
r (SDIO)	w requires that been signed to should be det	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	cause of death?
וומו וופרכ	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	Completed		0				24a. Was an autopsy performed	prior to come death?	sy findings available pletion of cause of
2	siciar certif recto	Be	25. Was case referred to medical examiner?	dospital:		Othe		th (Check only one)		
5	ding Phys h. After this funeral di	tion: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	ome 5 A Residence 28d. Describe how in	6 □Other (Specify) hjury occurred	
DIVISION	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funerat Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci	·hy)	eet, factory, office		City or Town, St	,	
	the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the cause red at the time, date	e(s) and manner as stat and place, and due to the	ed. ne cause(s)
	To with	2	29b. Signature and title of certifier	wo			2539	// M	Date signed (Month, De arch 10, 20	004
	F		30. Name and address of person who a	empleted cause of death (be	m 23a) (Type, I				we MO	2/239
Ì	Star Registra		31. Date filed (Month, Day, Year) MAR 1 1 2004	32. Registra Sign		,		-		

. )   0		210
State of Maryla	and / Department of Health ar	nd Mental Hygiene∠ U U

07460 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:40AM; Marca Szuch 2004 A1ma Claire /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel North Arundel Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 22, 1923 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔏 F PA 202-14-5584 80 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State I7 is marked other than "naturel", or Items 23a or 28a-f show traumatic event. The Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A. 7625 Marcy Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Item eny injury or other traumatic event. The Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Defense Contractor 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be George Winguard Belle Papke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7625 Marcy Drive, Glen Burnie, MD 21060 Mr. William Boyd - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Mar 10,2004 Crownsville, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. e of Funeral Marking Licensee 21. Signati 1 Second Avenue S.W., Glen Burnie, MD 21061 a 239. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Comcer resulting in death) /Medical Due to (or as a consequence of): Examiner Dreumann Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or s a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death ō Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Unknown ۾ 23e. Did tobacco use contribute to the cause of death? signed I Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 8 3 ☐ Probably 4 ☐ Unknown Yes Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22 No 24a. Was an certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 LInpatient 2 ER/Outpatient 3□ DOA 2 in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Injury 5 Pendina 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Day. 32. Redistrar's Signature Year State Registrar 1 1 2004

			For State Registrar	State of	Maryland		artmeni rtificate					giene Reg. No.	004	07461
			1. Decedent's Name (First, Middle	, Last)	<u> </u>						2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physici /Medic		Walter	Edward		Smi	th	J	r.		March	6	2004	05:54P M
i	Examin		4a. Facility Name (If not institution						Location	of Death			ounty of Death	
			Washington Ady	ventist Hos	pital				Park				Montgom	
	Funeral		5. Social Security Number	6. Sex 7. 1 □ X M 2 □ F	Age (In yrs. la 69		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dale of Bir (Month, De	th y, Year)	9. Birth	plece (Stete or Foreign
	Director		215-30-9028		09	Yrs.					Jan 8,	1935		MD
	pug *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					·		10d. Inside City Limits
	Aaryl • • ho	ō	MD Anne	Arundel	G1	en Bu	rnie						1	1 ☐ Yes 2 No
	28a-	ect	10e. Street and Number	Arunder	<u> </u>	CII Du	10f. Zip	Code				10g. Citize	on of Whal Cou	intry?
	with or a	ā	1424 Houghton	Poad			2	1061					USA	
	ma 23	era	11. Marital Status	12. Was Decede	ent Ever in U.S	5.   13.				igin? (Sp	ecify Yes or No Rican, etc.)	)- 14	. Race - Amer	
(0	r Iter	F.	1 ☐ Never Married 2 ☐ Marr	ied 1 Yes 2	es? √ZYNo						Hican, etc.)	1	Black, White	, etc. iite
03	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Date	es:		1 ☐ Yes :	ALX NO	Specify:				ipecify: Win	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itema 23e or 28e-f ehow he Medical Exeminer mast be notified at	Completed by Funeral Director	15. Deceden	l's Education st grade completed)		16a. Dece	kind of wor	rk done d	during mos	st of work	ing	16b. Kind	of Business/I	ndustry
21	ithin	du	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT us		1)			C+ > +	o of Ma	nyland
	ygier ygier her th	S	12	(		Insp	ector		19 Moth	or's Nam	e (First, Middle		e of Ma	rylanu
and	be fi	Be	17. Father's Name (First, Middle,								arie Wh		amamo,	
ž	2 should be filed within 72 hours and Mentat Hygiene. Is marked other then "netural", aumatic event, the Medical Exa	ဥ	Walter E. Smi  19a. Informant's Name/Relations			10h Maili	na Address	(Street			al Route Numb		Town State Z	in Code)
Maryland	12 st h and 7 is r traur		Mrs. Rose Smit								len Bur			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any Injury or other traumatic event, the Medical Examination must be notified at ance.		20a, Method of Disposition	II / WIIC	20b. Pla	ace of Dispo	sition (Nan	ne of		Mar!			ation - City or T	own, State
Baltimore,	Pages nent of int: If It		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			metery, crei lar Hi			ery	маr 2004	12	Brook	lyn, MC	)
量	nit. P artme ortan Injury		21. Signature of Funeral Service						_					ne, P.A.
Ba	permit. Departr Importa any Inju		MOT	- No	777						.W. G1			
43	70		23a. Part1. Enter the disease, or	complications that cau	ised the death.									Approximate Interval Between
3	Physician		shock, or heart failure. List Immediate Cause (Final		e 681	*								Onset and Death
	/Medical		disease or condition resulting in death)	d	as a consequ									
. 5	Examiner			Pre	umocu	18 Con	2 U	1 tes	ator	dis				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):	4 1		T					
	cuted nd ransi	Examiner	that initiated events	1 . Roc	lus ?		Mh	em	alor	na				
0	e exe ian au urial-t	EX	resulting in death) Last	Due to (or	r as a consequ		. 1.	-11	0.10					
8760,	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Ilcai		d Rel	e vase	_ ~	nole	SA	<del>COV</del>					
9	eath certifica attending pt for use as ti	Physician/Med	IF FEMALE:	OZa Musa autor	me of process	201							1.5	
Вох	eath c attend for us	ian	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal	death 3[	Ectopic pr		,			23	ld. Date of delin Month	Day Year
o.	the s	ysic	1 ☐ Yes 🏖 ☐ No 9 ☐ Unknown	9 Unknov	nt at time of de vn	am 5	Other (sp	ecily)						
<u>α</u>	that the deed by the detached	Ph.	Part II. Other significant conditi	ons contributing to dea	th but not resu	Iting in the u	inderlying o	ause giv	en in Part	1.	23e. Did	tobacco us	e contribute to	the cause of death?
ds,	w requires that s been signed t should be det	d by	Cogonati	arter	y di	seas	P				1 🗆	Yes 2 🗆	No 3 Pro	bably 4 XUnknown
Ö	v requ	ete			J						24a. Was	an	24b. Were au	onsy findings available
Records,	0 5 0	Completed									auto	psy ormed?	death?	opsy findings available ompletion of cause of
ā	ician: The l certificate ha	e Co	25. Was case referred to medica	1					OG Dies	o of Door	1 ☐ Yes	-	1 🗆 Yes	2 <b>X</b> No
Vital		To B	examiner?  1 Tes 2 No	Hospital:	patient 2 🗆 8	ER/Outpalie	nt 3 🗆 DO	Oth Oth	or		ome 5 Res		Other (Spec	ufv)
of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of (Month		28b. Time o		28c. Injur Wor			28d. Describe			.,,
ion	uttending F death. ctor: After y the funera	atlo	1 Natural 5 Pendii 2 Accident investi	'9	Day (66)	Injury	М		Yes 2	]No				
Division of	Atte	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   286. Place C	f Injury - At hor	me, farm, st	reet, factor	y, office			28f. Location (	Street and wn, State)	Number or Ru	ral Route Number,
Ö	tal or s afte al Dir ed in	Certification;			y, c.c. (opco.)									
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			ng Physician: To the b Examiner: On the bas										
	the H iin 24 the F	Medicai	one)	and manne	or stated.	10								
	To To	2	29b. Signature and title of certifie	WAR	KHAL	10 /18	HAT 29		e number	9		290. Date	signed (Month	L. Day, 10ar)
	w			The state of the s		140			033				1710	r
	1		30. Name and address of person		of death (Item	23a) (Type,	Print)	. Th	Ano	20	udan.	Hill	1 MA	20784
			31. Date filed (Month, Day, Year,	SHAI M	gistrar's Signat	urb Cons	0 12	1	11/	الماسي	VOI	, 000		- (0)
	St: Regist	ate rar	MAR 1 1 20	UA D	January January	a de la companya de l								

	1- For Amend Item #5 State of Maryland / Den Registrar Co	partment of Health and Mental   4 Fas ertificate of Death	Hygiene 2004	0746
Physician /Medical	Decedent's Name (First, Middle, Last)     HAROLD FREDERICK SHUSTER	2. Date o Month Marc	Day Year	Time of Death
Examiner	4e. Fecility Name (If not institution, give street and number) 7448 Cooper Point Road	4b. City, Town, or Location of Death Bozman	4c. County of Death Talbot	
Funeral Director	5. Factor Society 3000 for 1	Months   Days   Hours   Min.   (Month	f Birth b, Day, Year) 24,1932  New	
nutified at	Usuel Residence of Decedent   10a. State   10b. County   10c. City, Town or to   MD   Talbot   10c. City   10c.	_ocation Bozman		Inside City Limit
0 Z O	10e. Street and Number 7448 Cooper Point Road	10f. Zip Code 2 1 6 1 2	10g. Citizen of What Country? United Stat	
ar, or its	-	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:		ndian,
- 8	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) Lical Doctor	16b. Kind of Business/Industr	ry
od ott	17. Father's Name (First, Middle, Last) Morris Shuster	18. Mother's Name (First, Mi Bernice Ke		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1,1,1	ling Address (Street and Number or Rural Route No. Cooper Point Road,		
Department of Health Important: If Item 27 I amy injury or other tra	1 Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place)  Gifts Reg. 3/5/2004	20c. Location - City or Town, Hanover MD	State
Departr Importa any inju	21. Signature of Funeral Service Licensee  William M. Cuale  F		ain St. Federa	1sburg 21632
buria-Iransit and buria-Iransi		THY RILD (AN CER-	Inte	proximate erval Between set and Death
ittending physicia or use as the bur an/Medical	d	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	y Year
signed by the side be detached to be detached to be detached to be detached to be detached to be detached to be detached to be better to be detached to be d	Part II. Other significant conditions contributing to death but not resulting in the	and any my according to the many and any and any and any and any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any and any any any any any any any any any any	Did tobacco use contribute to the ca	
cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi  Completed by Physiclan/Medical Exami	CANCER PRISTATE HMPERTENSON		performed? death?	etion of cause of
beath. tor: After this certifi the funeral director catlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No	of 28c. Injury at Work?  M 1 Yes 2 No 28f. Locati	Residence 6 Other (Specify) ribe how injury occurred on (Street and Number or Rural Ro	oute Number,
Funeral Directely filled in by	4 Homicide building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	City o	r Town, State) the cause(s) and manner as stated	d.
within 24 hours after To the Funeral Dire completely filled in b Medical Certi	(Check only 2   Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and little of certifier  Thur from my			cause(s)
5	30. Name and address of person who completed cause of death (Item 23a) (Type ROBERT I HATTERS ON MID	BOOS, TALBUT ST	ST. MICHALIS	nu)
State Registrar	31. Date filed (Month, Day, Year)  MAR 1 1 2004	Coulet		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	SNYDER		For State Registrar	Ce	rtificate of Death	Reg.	No. 2004	0746
	Physici		1. Decedent's Name (First, Middle, Last) Dean Merrill Snyd			2. Date of Death Month MARCH 2	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give FRANKLIN SQUARE I		4b. City, Town, or Location of Deat		4c. County of Death BALTIMORE	1 3 3 3 3 3 3
· ·	Funeral Director		5. Social Security Number 6. Sec		If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth 2/24/193	9. Birth PA.	olace (State or Foreign ntry)
	Maryland	tor	Usual Residence of Decedent  10a. State MD. 10b. County Baltim	ore Essex	ocation			10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Il Direc	5 Brett Ct. Hopki	ns Village Apt.108	10f. Zip Code 21221	10g.	Citizen of What Cou USA	ntry?
980	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "neturel; or tlems 23s or 28e-f show event, the Medical Examitter" in the motified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 No If Yes, Give Korean	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 25(No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Baltimore, Maryland 21215-0036	within 72 ho ene. than "netur he Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  VLSOY		Constructi	
land 2	id be fited ental Hygi ked other ic event,	To Be Co	17. Father's Name (First, Middle, Last) Raymond Snyder		18. Mother's Nai Ethel (	me (First, Middle, Mai UNK)	den Sumame)	
Mary	s 1 and 2 should be t Health and Mental item 27 is marked o other traumatic ev	-	19a. Informant's Name/Relationship (Ty Anni Droski Frie		ng Address (Street and Number or Ri Anne Avenue Essex			Code)
more,	Pages 1 an nent of Heal snt: If item 2 sry or other		20a Method of Disposition  1 Burial 2XDC remation 3 P  4 Donation 5 Other (Specify)	20b. Place of Dispo competent cre Metro Cre	esition (Name of matory or other place) matory 3/8/	,	: Location - City or To Catonsvill	e Md. 21228
Balti	permit. Pages Department of I Important: If its any injury or or once.		21. Signature of Funeral Service License	I CO	2. Name and Address of FacilityCya 11 Chesaco Avenue			Home 21237
	Physician		Immediate Cause (Final disease or condition	cations that caused the death. Do not enter the cause on each line.	rer the mode of dying, such a cardia.	c or respiratory arrest,		Approximate Interval Between Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a cur equence of):	0			
68760,	icate be executed physicien and s the buriat-transit	sal Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Ω.	signed b	by	Part II. Other significant conditions con	stributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	ne cause of death?
Vital Records,		Completed				24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
f Vita	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  ↑ Yes 2 □ No	lospital: 1 ☐ Inpatient 2 🖔 ER/Outpatier	Other	ath (Check only one)	6 □Other (Specif	y)
Division of	r Attending ter death. irector: After by the fune	Certification:	27. Manner ol Death  1  Natural 2  Accident 3  Suicide 4  Homicide  2  Acmident 3  Suicide 4  Homicide	28a. Date of Injury (Month, Day Year)  3 - Z - O4  28b. Place of Injury At home, farm, structure building, etc. (Specify)	Work? 1 □ Yes 2 2 No eet, factory, office		d Struct and Number or Rura tate) 6950	Tofficup
_	Hospite 24 hours Funerel tely filled	Medical C		sicien: To the best of my knowlethe, death	h occorre at the time, date and place	, and due to the caus	e(s) and manner as s	tated.
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated	29c. License number O • C • M • E		Date signed (Month, MARCH 3,	Day, Year) 2004
	10,		30. Name and address of person who co	mpleted cruse of death (Item 23a) (Type,	Print) In Street, Baltimo	ore, Maryla	and 21201	
*	Sta		31. Date filed (Month, Day Year) MAR 1 2004	32. Registrar's Signature	els/			

State Registrar

			1 - State of Registrar		artment of Health a ertificate of Death		giene Reg. No. 200	4 07464			
3	Physici /Medic		1. Decedent's Name (First, Middle, Last) LEONA	SELLIG	ER	2. Date of Dea Month March	Day Year				
	Examir	er	<b>3</b>	Der) CENTER . Age (In yrs. last birthday)	4b. City, Town, or Location of BACTI ME	ORE	4c. County of Dea				
ı	Funeral Director		213-20-5409 1 M 25 Usual Residence of Decedent	78 Yrs.	Months Days Hours	Min. 5/23/1		aryland			
	Maryland	tor	MD 10b. County Baltimore	10c. City, Town or Lo Rosedal				10d. Inside City Limits 1 ☐ Yes 2\times No			
	h with the 23a or 284	al Director	1203 Primrose Avenue		10f. Zip Code 21237		10g. Citizen of What Country? USA				
920	72 hours after death with the Maryland "natural", or Items 23s or 28e-f show offeat Exemited must be multified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deced Armed Force 1 Yes 3 If Yes, Give Year or Date	es? No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 ☐ Yes 2 🕱 No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.			
21215-0036	swithin giene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	(Give	odent's Usual Occupation a kind of work done during most DO NOT use retired) emaker	of working	Own Home				
Maryland	should be filed and Mental Hygi s marked other umatic event, t	To Be (	17. Father's Name (First, Middle, Last) Theodore Rixham			r's Nam <i>e (First, Middle,</i> arri Martin	,				
	nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Type, Print)  August E. Sellier Husbar		ing Address <i>(Street and Numbe</i> 03 Primrose Ave						
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from St  4 □ Donation 5 □ Other (Specify)	ate   20b. Place of Dispo cometery, crea Gardens	matory or other place)	3/11/2004	20c. Location · City or Raspeburg 1				
Balt	permit. Departimport Import any inj		21. Signature of Funeral Service Lidensee		2. Name and Address of Facility 211 Chesaco Ave	'Cvach/Rose enue Roseda	dale Funera le Maryland	1 Home 1 21237			
	Physician /Medical		23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)		ter the mode of dying, such as of failure Fibrosi's	cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death			
P.	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underfying Cause (Disease or injury that initiated events c.	as a consequence of):	Fibrosi's	(IDio	pathic)				
68760,	icate be executed physician and s the burial-transit	dicai	resulting in death) Last  Due to (or	r as a consequence of):							
.O. Box	that the death certific led by the attending p detached for use as	Physician/Me	in the past 12 months?	nt at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year			
ords, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to dea	th but not resulting in the u	inderlying cause given in Part I.		ebacco use contribute to les 2 □ No 3 □ Pr	the cause of death?			
al Record	The law ate has b page 2 s	Completed				24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of			
f Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2√0 No Hospital: Ving	patient 2 ER/Outpatier	Other	of Death (Check only or sing Home 5 ☐ Resid	V	citv)			
ion of	ding h. After fune	ertification: T	2 Accident investigation	Injury 28b. Time o Day Year) Injury		28d. Describe h	ow injury occurred				
Division	= = = =	Certific	3 Suicide 6 Could not be 4 Homicide determined 28e. Place o building	f Injury - At home, farm, sti , etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,			
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the b 2 Medicel Examiner: On the bas and manne				and place, and due	10 1110 02230(3)			
)	^	Σ	29b. Signatur The of certifier Dariel	m.p.	29c. License number 2300 2		29d. Date signed (Mont Man L	h, Day, Year)			
	m		30. Name and address of person who completed cause BAYUEW MEDICAL MAR 1 1 2004	of death (Item 23a) (Type,	Print) Dean Do	alili, MD	n Avenue k	balto MI) 21224			
	Sta Registr	ite ar	31 Date filed (Month, Day, Year)  MAR 1 1 2004	gistrar's Signature	books						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2004 Year March 4, Lori Jean Sersen 10:50 a.m. Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Fecility Neme (If not institution, give street end number) Examiner Stella Maris Hospice Dulaney Valley Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 220-54-7179 8. Date of Birth 7 (M2)4+ 129 (5ear) 9. Birthplace (State or Foreign Maryland **Funeral** Days Hours 1 □ M 2 X F Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tten 27 is marked other than "naturel", or items 23s or 28e-f show other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Baltimore Middle River **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 12729 Cunninghill Cove Rd. 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1□Yes 2 No White Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Assist.Head Cook Balto, Co. Pub. School 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be filk Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic even RARS. Charles Walton Elaine Mathis 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Sersen Husband 12729 Cunninghill Cove Rd. Middle River, MD. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 3/6/04 Middle River Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral 1211 Chesaco Avenue Rosedale Maryland 21. Sign units of Funeral Service Licenses 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical BREAST CANCER Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Winknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Injury

signed by the ettending physician end d be deteched for use es the buriel-trensit The law requires thet the death certificate be executed of Vital Records, P.O. Box 68760, is certificate has been si director, page 2 should After this certificate

Maryland 21215-0020

Baltimore,

2004

To the Hospital or Attending Physimithin 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral directors. Division

LORI SERSEN

5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4372

29b. Signature and title of certifier

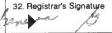
29c. License number 29d. Date signed (Month, Day, Yeer)

104

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year) MAR 1 1 2004



		•	For State Registrar	State of Ma	rylar		rtment <i>tificate</i>			l Me		giene Reg. No.	2001	0746
20 A	Physicia	_	Decedent's Name (First, Middle, Last		NE	TESTER	MAN			2	2. Date of Dea Month March	Day	Year 2004	3. Time of Death 6:00 A M
	/Medic Examin	er	4a. Facility Name (If not institution, give  Corisa Hill  5. Social Security Number 6. S	Nursing Ho		last birthday)		ntei	Location of De ville		R Date of Birt	Que	en Ann	ne's
	Funeral Director			M 2∏ F 7. Age	95	Yrs.		Days		in.	3. Date of Birt (Month, Da) Oct 15	, Year) , 190	8 W.	hplace (Stete or Foreign untry) Va.
	the Maryland 28a-f show	ctor	Maryland Quee	n Anne's	10c. Cit	ty, Town or Lo S	cation tevens	svi1	.1e					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	eath with the Maryla is 23e or 28e-f show	ai Director	10e. Street and Number 512 Z	aidee Lane			10f. Zip (		21666				on of What Co USA	
920	or Item	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		}	Vas Decede f Yes, speci l ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Speci erto Ri	ify Yes or No- ican, etc.)	S		hite
21215-0036	- × 32	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) unknown	ducation ide completed) College (1-4or 5- unknown	+)	(Give	lent's Usual kind of work DO NOT use memak	done of	ation luring most of a )	vorking	7		sewife Moth	&
Maryland 2	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, tha M	To Be C	17. Father's Name (First, Middle, Last) William		on				18. Mother's Mari	an	Newbe	rry		
	is 1 and 2 sho of Health and item 27 is my other traumy		19a. Informant's Name/Relationship ( Ronald Testerman		-	512	Zaide	e La	ane, S	tev	ensvil	le, M	ld. 21	.666
Baltimore,	permit. Pages 1 Department of He Important: If iter any Injury or oth		20a. Method of Disposition  1 ☑ Bunal 2 ☐ Cremation 3 ☐  1 ☐ Other (Specif.	y)	Ce	Place of Dispo cemetery, creme edar Hi	natory`or oth	nete	ry   3,		/2004	Balt		Maryland
Balt	permit. Depart Import sny Inj		21. Signature of Funeral Specice Licer			2	37 E.	Pat		lve.	., Balı	.0.,	P.A. Md. 2	1225-1856 Approximate
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	plications that caused one cause on each lin  a  Due to (or as a	e. I consec	Alzl quence of):	er the mode		g, such as card	lac or	respiratory ar	rest,		Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a	consec	quence of):								
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1 D Live birth 4 Pregnant at 9 Unknown	2 Fete	el death 3	Ectopic pre Other (spe					230	d. Date of del Month	ivery Day Year
<u>α</u>	8 6 8		Part II. Other significent conditions of	contributing to death bu	it not res	sulting in the u	nderlying ca	use give	en in Part I.	_	23e. Did to	_		the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed								-		an sy rmed? 2540	24b. Were au prior to death? 1  Yes	topsy findings available completion of cause of 2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		7.50/0		Othe	26. Place of [				701 (0	-41
of		lon: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending	1 ☐ Inpatie		28b. Time of Injury		c. Injury Work	at (? Yes 2 □ No		d. Describe		Other (Spec	eny)
Division	tend death tor: the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Osa Blaca of Init	iry - At h . (Speci	nome, farm, str ify)				28	8f. Location (S City or Tox		Number or Ru	ıral Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Examone)	nysician: To the best on miner: On the basis of and manner sta	examina	owledge, death ation and/or in	vestigation,	in my op	pinion, death or	ace, an	at the time,	date and p	lace, and due	to the cause(s)
	To the total	Σ	29b. Signature and title of centifier	Sum	0		29c.	License	32US	6		3 // <b>2</b>	signed (Monti	n, Day, Year)
	/y		30. Name and address of person who	in 2/1	P	12. 1	Print)	h	prive	C	huh	m	1210	19
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Sign	ature	/							

ORIGINAL

4-01448 rn		_ For	ype or Print State of Mar	yland / Dep	artment of	Health and		ygiene _			
		1 - State Registrar		Ce	rtificate o	t Death	O Data of D		004 0746		
Physici	an	1. Decedent's Name (First, Middle, Last)	ma.c				2. Date of D Month	Day	Year		
/Medic	al	Beatrice Kay Thom  4a. Facility Name (If not institution, give s			4h City Town	, or Location of Dea	Februa Th	ry 26, 2			
Examin	ier	201 Warren Avenue		+ 204	Balti			N/			
Funeral Director		5. Social Security Number $unk$ 6. Sex	7. Age (	In yrs. last birthday		ar If Under 24 Hr	s. 8. Date of B		9. Birthplace (State or Forei Country) UNK		
p ,		Usual Residence of Decedent		0c. City, Town or L	coation				10d. Inside City Limit		
arylar show	5	10a. State 10b. County		*	timore	1 √ Yes 2 □ N					
the M	Director	10e. Street and Number 10f. Zip Code 201 Warren Avenue #204 21230						10g. Citizen of	What Country?		
2 should be filed within 72 hours after death with the Maryland and Mentle House 1990 in and Mentle House 23s or 28s-f show aumatic event. The Medical Examinational be nutified at								U	USA		
	Funeral		er in U.S. 13	. Was Decedent C	of Hispanic Origin? ( uban, Mexican, Pue		- 14. Race - American Indian, Black, White, etc.				
	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No unk If Yes, Give Year or Dates:  If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:					Specia			
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elamentary/Secondary (0-12) unk  College (1-4or 5+) unk  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business (Infe. DO NOT use retired)							Business/Industry U		
	Be	17. Father's Name (First, Middle, Last)			un	k 18. Mother's Na	ame (First, Middl	le, Maiden Surnai	me) u		
and 2 should ealth and Men m 27 is marke	2	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mai	ling Address (Stre	et and Number or F	Rural Route Num	ber, City or Town	, State, Zip Code)		
nd 2 s Ith an 27 is		O.C.M.E.	,			reet Balt					
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 ☒ Other (Specify)	emoval from State	20b. Place of Disp			Date		- City or Town, State		
permit. P Departme Importan any injury		21. Signature in the properties of Facility  22. Name and Address of Facility  State Anatomy Board 655 W. Baltimore Street  Baltimore, MD 21201									
Physician /Medical		23a. Partt. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Tramado	e death. Do not end of intoxic consequence of):		tying, such as cardi	ac or respiratory	arrest,	Approximate Interval Between Onset and Death		
be executed cian and cian and purial-transit	Examiner	Sequentially list conditions,  a y, keding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
the burial		d									
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir		Date of delivery Month Day Year						
wrequires that the second of t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to							atribute to the cause of death?		
The law requate has been page 2 shou	Completed						Yes Yes	opsy formed? 2 \Begin{align*} No	Were autopsy findings available prior to completion of cause of death?  1 Yes 2□ No		
Physicien: r this certitic ral director,	Be c	25. Was case referred to medical examiner?	examiner?						her (Specify) at scene		
To the Hospitel or Attending Physicien: The lawithin 24 hours after death.  To the Funerel Director After this certilicate has completely filled in by the funeral director, page 2	- To	10 Yes 2 No 1 Impatient 2 LEM Culpatient 3 LOA 4 Nursing nome 5 Impatience 6 United (Specific Notes)							itel (Specify)		
	tlor	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation Found: 2-26-4 Unk				Vork? □Yes 2⊡No	m				
	Certification;	3 Suicide SE Could not be determined	28e. Place of Injury - At home, farm, street, factory, office			City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State) 201 Warren Ave., Baltimore, MD				
	edical C	29a. Certifier  (Check only (Check only and manner stated)  29a. Certifier  (Check only (Check only and manner stated)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within 2 To the comple	Med	29b. Signature and title of cerulier	29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) February 26, 2004					
		30. Name and address of person who co	moleted cause of dea	ith (Item 23a) (Type	e. Print)						
		I Uffor low	be, MD			Street, I	Baltimor	e, Maryl	and 21201		

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 1 2004

		•	For State Registrar	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2							2006	07468	3
	Physicia	an	1. Decedent's Name (First, Middle, Last)	-	TINSLEY				2. Date of Death Month Day Q Year 1209 1209				
	/Medic Examin		4a. Facility Name (If not institution, give				ion of Death	10/01000	-	County of Death	)	_	
			Howard County Gen				umbia	ider 24 Hrs.	0.000		loward	-1	_
	Funeral Director		5. Social Security Number 6. Security Number 1.579-09-68.38	7. Age (In yrs.	Yrs.	Months	Days Hou		8. Date of Bird (Month, Da JUNE 2	y, Year)	1917 Was	plece (State or Foreign intry) hington DC	
	pur *		Usual Residence of Decedent  10a. State 10b. County		ty, Town or La	cation						10d. Inside City Limits	_
-UU36 hours after deeth with the Maryland	Maryla -f sho	tor	Maryland Howard		umbia							1 ☐ Yes 2 No	
	or 28a	Funeral Directo	10e. Street and Number				Code				izen of What Cou	untry?	
	s 23a	erail	11068 Berrypick La	ane 12. Was Decedent Ever in U	19 13 1	210		Origin? (Sp	ecify Yes or No	USA	14. Race - Amer	ican Indian.	_
	I within 72 hours after deeth with the Marylan ilene. Ithen * natural; or ttems 23a or 28a-f show the Mudical Examiner mast be notified at	by Fune	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		if Yes, spe	cify Cuban, Mex	cican, Puerto	Rican, etc.)		Black, White Specify:		
2-003p	72 hour natural'	ted b	15. Decedent's Edu	cation	16a. Dece	dent's Usu	al Occupation	most of work	ang.	16b. K	ind of Business/I		_
7	within 7 lene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)			ork done during se retired) tive As			D C	Conora	l Hospital	
7	9 5 9 -		17. Father's Name (First, Middle, Last)		Admin	LSLIC			e (First, Middle,			ii iiospitai	_
/land	d and a	To Be	Joseph L. Tinsley					Rosa Ann Thomas					
Man	and and ls m		19a. Informant's Name/Relationship (7)			-					MD 210		
	s 1 and r Health fem 27 other to		Concha A. Tinsley, 20a. Method of Disposition	20b. i	Place of Dispo cemetery, crer	sition (Na	rypick	Lane	Columb Date		MD 210 ocation - City or T		-
Ē	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State Mo	tro Cr	emato	ry Inc.		1-04		altimore	e, MD	
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ott		21. Signature of Fungral Service Licens Thomas Gregor	Ty-	Či 29	remat 99 Fr	ion Soc ederick	iety c Road	of MD, I Balti	nc.	e, MD 2	1228	
	ás.		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									Approximate Interval Between Onset and Death	
÷.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):								48M	_
ē	Examiner	16	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):								48 m	
petn	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	COLONIC PENFORATION								2 wk	_
60,	certificate be executed iding physician and use as the burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequence of):  ATHENSCALOVICE							PEAN.C		
09/89	tificate by physical as the t	edicai		d. BIRETURE								10112	_
Geath death death death		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of 0 9 □ Unknown	al death 3	⊒Ectopic p ⊒ Other (s					23d. Date of deli Month	very Day Year	
0	as the	by	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	inderlying	cause given in F	Part I.	23e. Did t		use contribute to	the cause of death?	
Records,	w require been sig should b	leted	DOMBAT (IA						24a. Was			topsy findings available	_
	The lay	Completed							auto		prior to c death?	ompletion of cause of 2 No	
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:	_		Other		th (Check only o				_
VISION OF Attending Ph r death. ector: After the	ng Physic ter this oneral dir	on: To	1 Yes 2 No  27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of North Work?  1 Yes 2 No			JOA 4 Nursing Home 5 Hesidence 6			<u>, , , , , , , , , , , , , , , , , </u>	ufy)	_	
	ttendii death. ctor: A / the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				28f. Location (Street and Number or Rural Route Number,				_		
	Itel or A rrs after ref Directled in by	Certification:	4 Homicide building, etc. (Specify)				City or Town, State)						
	To the Hospitel or within 24 hours affect to the Funerel Dir completely filled in	Medical		rsician: To the best of my kn iner: On the basis of examin- and manner stated.									
ì	To th within To th compl	Me	29b. Signature and title of certifier			29c. License number				29d. Date signed (Month, Day, Year)  March 9, 200 4  MD 21044			
•			30. Name and address of person who co		m 23a) /Tupo		>311	12		1110	rest 1	1007	_
	12		H.A. DKESS 10	700 CHANTE	in A	12	00 0	aum	BIA	M	0 21	044	
	Sta Regist		31. Date filed (Month Day Year) MAR II 2004	32. Registrar's Sign	ature	2							

	٠	1 - For Amend Item#1& #8 Registrar Unpend Item#23	State of Ma a,27,Per M	aryland / Depa <b>:,0829,3/16/0</b>	artment of H	lealth and N Death	Reg	ene2004	
Physic		Decedent's Name (First, Middle, Last)		Wheeler, S			2. Date of Death Month March	Day Year 07, 2004	3. Time of Death 17:08 M
/Med Exami		4a. Facility Name (If not institution, give s		Wileelel, 5		r Location of Death	1102011	4c. County of Deat	
		2019 Jeanne Avenu				thorpe		Baltimor	e
Funeral Director		5. Social Security Number 6. Sex 1215 60 3854	M 2□F 7. Ag	(In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	(ear) Co 1953 Ma	hplace (State or Foreign untry) aryland
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Marylan i-f ehow	tor	Maryland Baltimon	ce	Haletho	rpe				1 ☐ Yes 2X No
with the	I Director	10e. Street and Number 2019 Jeanne Avent	ue		10f. Zip Code 2122	27	100	g. Citizen of What Co	untry?
nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after deeth with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Mexical Evania at minist te roulling at	by Funeral	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036  d within 72 hours aff giene. er then "naturel", or , the Mexical Exerci-	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	ing	6b. Kind of Business/	Industry
212 d with giene.	Local Line	Elementary/Secondary (0-12) 7th	College (1-4or 5	Shee	t Metal N				on Company
Maryland 2121 d 2 should be filed within the and Mental Hygiene. 7 is marked other than "treumatic event, the Men	To Be	17. Father's Name (First, Middle, Last) Gilbert	Wheeler				e (First, Middle, Ma y Agnes	aiden Surname)	
ary shoul and Ma s mari	F	19a. Informant's Name/Relationship (Typ				and Number or Rui	al Route Number, (	City or Town, State, 2	Zip Code)
e, Marand 2 Health a tem 27 is other tree		Ronald Wheeler J	r. / Son		ale Road			Maryland	
Baltimore, M permit. Peges 1 and 3 Depertment of Health Important: If item 27 ens, injury or other tr		20a. Method of Disposition  1 ☐ Burial 2 【 Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		osition (Name of matory or other place Crematory	ce)		Oc. Location - City or Baltimore,	
Baltime permit. Peg Depertment Important: I eny injury o		21. Signature of Funeral Service License	-amissi	-//	2. Name and Addre	ss of Facility Go ie Highwa	nce Funer y Balti	al Servic	e, P.A. yland 21225
		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final		the death. Do not entended.			or respiratory arres	it,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		a consequence of):	HOVEXCHEE	DISCUS			
Examiner		Sequentially list conditions,		s consaquence off)					
cuted nd ransit	Examiner	if any, leading to initial ordats cause. Enter Underlying Cause (Disease or injury that initiated events							
8760, cate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequence of):					
BOX 6 death certifi e attending	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	у		23d. Date of del Month	ivery Day Year
ords, P.O requires that the seen signed by th hould be detache	d by Ph	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	
Sec e law has b	omplete						24a. Was an autopsy performe	prior to death?	atopsy findings available completion of cause of 2 \(\sum \) No
f Vital F ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					th (Check only one)		
9 7	2	1  Yes 2 No Path	lospital: 1 ☐ Inpate 28a. Date of Inju			4   Nursing H	ome 5 Residen 28d. Describe how	ce 6 Nother (Specialist of the Control of the Contr	city) SCENE
Division of To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Da		M 1□			et and Number or Ri	ura I Route Number
pitel or A burs after eral Direc	Certif	4 Homicide determined	building, et	c. (Specify)	reat, factory, office		City or Town,		
he Hospi in 24 hou he Funei pletely fil	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis of and manner st	of my knowledge, deat f examination and/or in ated.	vestigation, in my o	ppinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
To the within 2 To the complete	Σ	29b. Si nature sid tit of certifier	M		29c. Licens	o.C.M.E.		d. Date signed <i>(Mont</i> arch 08, 2	•
		30. Name an address of person who co	pleu d cause of o	leath (Item 23a) (Type,		et, Balti	more, Mai	ryland 212	01
	tate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	books				
Regis	trar	FOR 1 1 2004	production of the same	1- 1-					

State of Maryland / Department of Health and Mental Hygienes 1- For Secistrate Unpend Item#23a,27, PerMe,G830,4/7/OverCertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 7, Day 2004 **Physician** 3:40 P M YOUNG JAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner n/a 708 S BOND ST BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Aug. 02 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 220-70-2112 46 1957 Washington D.C Director Aug. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show other traumatic event, the Mudical Examiner must be nutified at Baltimore 1X□Yes 2□No Md. n/a Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 U.S.A. 21231 708 S. Bond Street or Items 23a death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after and Mental Hygiene. 17 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Food Service Elementary/Secondary (0-12) College (1-4or 5+) Waiter 12 0 Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley Lemley Charles Young 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heatth and Important: If Item 27 is m eny injury or other traum 6408 Warm Sunshine Path, Clarksville, Md.21029 Leslie Granhn (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 03/11/04 Bavview Crematory Baltimore, Md. McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses Tund 3204 Mountain Road, Pasadena, Md. art1. Enter the disease, or compligations that glused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death mmediate Cause (Final Probable Sepsis **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine as the burial-transit requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 X Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 X Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lep Joisha 2 OCME MARCH 8, 2004 treenberg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 L Greenberr asha 31. Date filed (Month, Oay, Year) 32. Registrar's Signature State rocks Registrar 1 2004

			1 - For State Registrar	State of Maryla	nd / Dep		Health and		iene 19. No. 200	4 07471
	Physici /Medio			ST		-		2. Date of Deat Month MARCH	8TH 200	4 2:05 PM
	Examir	er	4a. Fecility Name (If not institution, give  NORTHWEST Ltos  5. Social Security Number 6. Se	SPITAL CEI	VTER	RAND	or Location of Dea	72	1	imore:
	Funeral Director		217-16-8403 15 Usuel Residence of Decedent	X <sup>M 2□F</sup> 79	Yrs.	Months Day:	s Hours Min	8. Date of Birth (Month, Day, July 9,	1924 Ma	Birthplace (State or Foreign Country) aryland
	the Marylar 28a-f ehow	ector	Maryland  10b. County  Maryland	10c. C	Balti			J 1	0g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	sath with	Funeral Director	6003 Gwynn Oak Avo	enue	15 12	2120			USA	merican Indian,
960	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be mullind an	by	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: WWI	_	1 ☐ Yes 2 🕅 No		(Specify Yes or No- erto Rican, etc.)	Black, W	hite, etc.
Maryland 21215-0036	within 72 h ene. then "natu he Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	(Give	edent's Usual Occi e kind of work don DO NOT use retir	e during most of w ed)	orking	16b. Kind of Busine	
land 2	uld be filed Jental Hygisirked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Walter Yost				18. Mother's N	ame (First, Middle, M ith E. Har	Maiden Sumame)	iarytana
	nd 2 shoul alth and Ma 27 is mari		19a. Informant's Name/Relationship (T)  Irene Yost	ypa, Print) Wife				Rural Route Number, e:Baltimor		
Baltimore,	Pages 1 and 2 lent of Health nt: if item 27 iry or other tri		20a. Method of Disposition  1 XBurial 2 Cremation 3 I  4 Donation 5 Other (Specify,	Temovariioni State	Place of Disp cemetery, cre	osition (Name of or other plants) Mem. Pa	ace)		20c. Location - City	or Town, State
Balti	permit. Pages 1 Department of H Important: if ite eny injury or ot once.		21. Signature of Funeral Service Ligens	- delt	2	Sterling 736 Edmo	ess of Eacility AShton	Schwab Fu enue;Balt	neral Hom	ne, Inc.
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the dea one cause on each line.		iter the mode of dy $F$		ac or respiratory arre	est,	Approximate Interval Between Onset and Death
*	/Medical Examiner	er	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):					
,092	icate be executed physicien and s the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):					
P.O. Box 68	The law requires that the death certificate to the law requires the latending physic age 2 should be detached for use as the boage.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of o	delivery Day Year
	w requires that been signed b should be dete	þ	Part II. Other significant conditions co	-	sulting in the o	underlying cause g	iven in Part I.			e to the cause of death?  Probably 4 Unknown
Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior t	
	ling Phy  After this uneral d	tion; To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Inj	ther: 4 🗌 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (S	pecify)
Division of	al or Attending after death. I Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, st			28f. Location (Sti City or Town		Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edica	29a. Certifier (Check only one)   Certifying Phyone   Medical Example	ysician: To the best of my kr iner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the nvestigation, in my	time, date and plac opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)
)	To the within	Σ	29b. Signature and fittle of certifier.	) १भ५६	CLAN	,	2723	m	9d. Date signed (Mg	H 2004.
	10		30. Name and address o person who c	***************************************		Print) 0 (	3 W F D	57 14056	UTAL AD MI	CEM1=12 21133
E	Sta Regist		31. Date filed (Manh, Pay-Year) 20(	32 Registrar's Sign	ature					

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Obeta of Manuford / Deportment of Health and Montal Hydiana				- 11	- 1	ž,
State of Maryland / Department of Health and Mental Hygiene	U	, v	4	U	- 7	ч

		1	1 = For State Ragistrar	State of Maryland / [	Department of He Certificate of De	eath	Reg. N		0/4/2
4	Physicia /Medic		Decedent's Name (First, Middle, Last)     Ex	velyn	Askins	F	Date of Death Month Druary	<sup>0a</sup> 11,2 <sup>0</sup> 04	3. Time of Death 2140 M
	Examin	_	4a. Facility Name (If not institution, give so Memo)	rial Hospital	4b. City, Town, or Lo East		4	4c. County of Deeth Talbo	
Y	Funeral Director	1	5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 200 F 86		Hours Min.	Date of Birth (Month, Day, Yea Sept. 17, 1	9. Birth Cou	plece (State or Foreign ntry) land
	D	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits 1 (XYes 2 □ No
	th the Ma 7r 28a-1 s e notifies	Director	Maryland Queen Ai	nnes Gra	.sonville 10f. Zip Code		10g. (	Citizen of What Cou	
	be filed within 72 hours after death with the Maryland that Hygiene.  Identify than "natural", or flems 2 2, 28a-1 show od other than "natural", or flems 2 2, 28a-1 show event, the Medical Exam ratin be notified at	Funerail	P.O.Box 361  11. Marital Status  1 Never Married 2 Marned	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No	21638  13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	USA  14. Race - Ameri Black, White,	
-0036	2 hours aft stural, or	by	3 Widowed 4 Divorced	Year or Dates:	. Decedent's Usual Occupation	Specify:	16b.	Specify: B1a Kind of Business/In	
21215-0036	e filed within 7/ al Hygiene. other than "n vent, the Wedl	Completed	(Specify only highest grade Elementary/Secondary (0-12) UNK	College (1-4or 5+)	(Give kind of work done dur life. DO NOT use retired) cocessing Sea	afood		Seafood E	lant'
land	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Clarence Askin	s, Sr	1	8. Mother's Name (	First, Middle, Maid Jacks		
Man	she and series		19a. Informant's Name/Relationship (Tyg. Montro Wright, S		o. Mailing Address (Street and PO. Box 202, Gr				) Code)
Baltimore, Maryland			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	of Disposition (Name of ary, crematory or other place)  Neck Cemeter	ry 02/18		Location - City or T	
Balti	permit. Page Deportment of Important: If any njury or once.		21. Signature of Funeral Service License		22. Name and Address Bennie Smi 426 Dove	of Facility			
<b>本点</b>	Physician		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. Do e cause on each line.		such as cardiac or			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Duelto (or as a consequence	(				Days
68760,	icate be executed physician and s the burial-transit	ai Examiner	Sequentiarly rist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	, iq				Days
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.O. Box	at the death certific by the attending I tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	Day Year
٩	juires that I n signed by Ifd be deta	by	Part II. Other significant conditions con	stributing to death but not resulting	in the underlying cause given	in Part I.		co use contribute to to 2 No 3 Pro	the cause of death? bably 4 Munknown
Records,	The law requires that the ate has been signed by the page 2 should be detache.	Completed					24a. Was an autopsy performed	? prior to co	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	0.4	26. Place of Death			
of	ing Phys After this uneral di	tion: To	27. Manner of D. ath	28a. Date of Injury 28b.	Time of 28c. Injury a Work?	4   Nursing Hom	e 5 Residence	6 ☐Other (Speci njury occurred	<b>y</b> )
Division	al or Attending efter death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28	of. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical C		sician: To the best of my knowledg nar: On the basis of examination at and manner stated.					
	To the within. To the comple	Me	29b. Signature and title of certifier	udipuothan	29c. License r	5 749		Date signed (Month,	Day, Year) 122004
•			30. Name and address of person who co	The state of the s					
	St Regist	ate	Dr. Lakshmi 31. Date filed (Month Day Year) 7 E 8 2004	Vaidyanathan,  2. Registrar's Signature	hours	Scott Dele	,	,,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 07473 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 13 12:34 P<sup>M</sup> February 2004 Adams Agatha Hope /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecifity Name (If not institution, give street and number) Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗷 F Yrs. Director 3, 1915 Maryland 219-56-2248 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County r then "natural", or Itams 23a or 28a-f show the Modical Exercines must be notified at 1 Yes 2 No Directo St. Mary's Maryland Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25033 Sotterley Road 20636 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home should be filed and Mental Hygies marked other t of Health and Mental Hygie I Item 27 is marked other in other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٥ Mary Agnes Wible George Clarence Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Michael Adams / Son 25023 Sotterley Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 Buriaf 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 2-18-2004 Hollywood, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Econsee

Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio respiratory **Physician** /Medical Hypestention **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit Aostic CINCUTYSM Abdominal resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 📉 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient ို 3X DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural
2 Accident 5 Pending Injury 1 Yes 2 No investigation To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47066

Registrar

D

Ashah

AVANI D. SHAH M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.BOX404

32. Registrar's Signature

LEONARDTOWN, MD. 20650

DHMH 17 Rev 1/2001

Registrar

		_,	1 - For State Registrar	State of Maryland		artment of Hertificate of L			ene2004	07475
	Physici	an	Decedent's Name (First, Middle, I  JOHN		חח			2. Date of Death Month	Dev Year	
3	/Medic Examin		4a. Fecility Name (If not institution, g	R. APPLEYAI	Kυ	4b. City, Town, or	Location of Death	FEBRUARY	20 2004 4c. County of Dea	
			Montgomery Gene	eral Hospital		01ne			Montgo	
	Funeral Director		5. Social Security Number 6. 213 90 0410  Usuel Residence of Decedent	Sex   7. Age (In yrs. last   70	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 28	9. Bi 1933 E	rthplece (State or Foreign ountry) ngland
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
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	with 11	Dire	10e. Street and Number 18321 Dutchess	Drive		10f. Zip Code 2083	22		g. Citizen of What C	•
	death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar			United St	erican Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ahow the Madical Exercities mast be incitied at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			Tes, specily cubar	Specify:	rican, etc.)	Black, Whi	te, etc. White
2-0	72 hou natura	eted	15. Decedent's (Specify only highest of	Education	16a. Deced	lent's Usual Occupa	tion	ina 1	6b. Kind of Business	Vindustry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)	ning most of work	"ig	T	****
<b>d</b> 2	illed Hygie other	Be Co	17. Father's Name (First, Middle, Las		ENG	gineer	18. Mother's Name	e (First, Middle, M	Transpor	tation
Maryland 21215-0036	should be nd Mental nmarked o	ToB	Norton Appley				Elsie	Humphr		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If there 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be nutitied at once.		19a. Informant's Name/Relationship Margaret J. Appl		19b. Mailin	g Address (Street at 21 Dutches	od Number or Run SS Drive,	al Route Number, Olney,	City or Town, State, Maryland	Zip Code) 20832
Baltimore,	Jes 1 a		20a. Method of Disposition 1 □ Burial 2 🎖 Cremation 3	Removal from State	ce of Disponence	sition (Name of natory or other place	)		Oc. Location - City or	
Ħ	nit. Pages artment of ortant: If It injury or o		*4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	eify) Metr		itan Crem.	1		Alexandri	a, Va.
Ba	Department of the partment of		Muriel	21- Barber	∠   'ħ	Name and Address Nuriel H. P. O. Box				20882
	- 5/2 - 5/2 - 5/2		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death. y one cause on each line.	Do not ente					Approximate Interval Between Onset and Death
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	Examiner		Sequentially list conditions,	6. CORONA	RY	AR-	7503Y	DIS	EBSE	MONTHS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (or as a consequer	nce of):					
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ROX	eath certific attending p	an/M	IF FEMALE: 23b. Wes decedent pregnant	23c. If yes, outcome of pregnance		Ectopic pregnancy			23d. Date of de	
o.	0 0 0	Physician/Me	in the past 12 months? 1  Yes 2 No 9 Unknown	4 Pregnant at time of deet 9 Unknown		Other (specify)			Month	Day Year
<u>ര്</u> പ	gne be d	by Pt	Part II. Other significant conditions	contributing to death but not resulting	ng in the un	derlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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0	g Physer this end directly	n: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 NER	VOutpatient Bb. Time of	3 DOA 28c. Injury a Work?	4   Nursing Hor	me 5 Residence R	ce 6 Other (Specinjury occurred	cify)
<u>S</u>	eath. or: After the funer	catlo	1 DNatural 5 Pending 2 Accident investigation	on	Injury	M 1 TY	s 2 No			
DIVISION	al or Attending F s after death. I Director: After d in by the funers	ertification:	3 Suicide 6 Could not determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	4	28f. Location (Stree City or Town, 1	et and Number or Ru State)	ral Route Number,
	2 6 6 0	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
,	To th withir To th comp.	₩ W	29b. Signature and title of certifier	2 0 00		29c. License r	number	29d	. Date signed (Montl	n, Day, Year)
	12		Jam 10	Demille	M	> 50	5809	, c	2 21	04
			30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, P	20 -1	CILN	ev On	(D) N12	Ex 10 20632
	Stat Registra		31. Date filed (Month, Day, Year) FEB 2 3 20	32. Registrar's Signature	5	Sparker		1	7 2 10 3	1110
	ricgiotic		LED 29 50	) A   / P	,	/				

			1 - For State Registrar	State of Maryla	and / Depa		of He	ealth ar	nd Mental H	ygien	_		074	. 76
	Physic	ian	Decedent's Name (First, Middle, Last						2. Date of D	Da	ay '	Yeer	3. Time of	Death
	/Medi	cal	Howard W. Arendt						Febru	ary .	L9, 20		1429	M
€,	Exami	ner	4a. Fecility Name (If not institution, give		7			Location of I	Death		. County of			
	Funeral		Shady Grove Adven  5. Social Security Number 6. Se		. L s. last birthday)	Rockv If Under 1		e If Under 24		irth	lontgo			r Foreign
b	Director		402-22-0810	ŽM 2□F 79		Months	Days	Hours	Min. (Month, I Sept.	lay, Year	924	Count	ace (State or try)	roreigir
	pu .		Usuel Residence of Decedent  10a. State 10b. County	100	City, Town or Lo					<i>-</i>				
	Aaryle Fettor	ō										10	od. Inside City 1 X Yes	•
	the A	ect	Maryland Montgome 10e. Street and Number	ry R	ockvill	e 10f. Zip C	'oda			10- 0	A:			2   140
	3a or	0	1218 Fallsmead Wa	37		2085					tizen of Wh			
	hours after death with the Maryland turel, or items 23a or 28a-f show at Exercities must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13. \			panic Origin	n? (Specify Yes or No Puerto Rican, etc.)		ted S			
9	after or the	Fu	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ÄYes 2 □ No Wo	orld	lYes,specify 1 □ Yes 2]∑			Puerto Rican, etc.)			White, e	itc.	
00	ure!;	d by	3 Widowed 4 Divorced	Year or Dates: Wa	ar II	1 1 1 8 2 Z	7 140	эреспу:			Specify:	Whi	te	
15-	n 72 net	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual ( kind of work   DO NOT use	Occupat done du	ion <i>ring m</i> ost o	f working		(ind of Busi		ustry au of	
712	withi iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		ial Ag					estig			
p	illed I Hyg other	BeC	17. Father's Name (First, Middle, Last)		- Spec.	115		8. Mother's	Name (First, Middle				, II	
/lar	uld by Wenta rrked rifc e	To E	George M. Arendt					Wilh	elmina Hu	ber				
Maryland 21215-0036	2 sho and I		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (S	Street an	d Number o	or Rural Route Num	ber, City o	or Town, St	ate, Zip (	Code)	
	and lealth im 27		Dorothy A. Arendt		1218	Falls	mead	l Way,	Rockvill	e, M	aryla	nd	20854	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or itama 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exprinting must be notified at anote.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State A	Place of Disportant Control Place of Disportant Control Place of Disportant Place of D	sition (Name natory or othe Natio	of er place)	Ma	rch 30,	20c. L	ocation - Ci	ty or Tow	m, State	
Ħ	rtmer rtmnt rtant njury		'4 □Donation 5 □ Other (Specify)  21. Signature of Fineral Service Lipense		Ceme	etery		; 20		Ar1	ingto	n, V	irgini	ia ,
Ba	Department Department of the post of the p		21. Signature of Furieral Service Libers		Ko	ockvil.	Le.	inc.	Robert A. 300 West	Mon	tgome	ry A	eral F venue	lome/
40	\$ . Sec.		23a. Part 1. Enter the disease, or compli	ications that caused the dec	0803 Ro	ockvil	Le,	Mary L such as car	and 2085	0-28	05		Approximate	
	Physician		Immediate Cause (Final	te cause on each line.			, 3.					1	Interval Betwo	een
	/Medical		disease or condition resulting in death)	Aspiration  Due to (or as a conse		onia					_	-		
E	Examiner		Sequentially list conditions	Atrial Fil		ion								
	D ==	iner	if any, leading to immediate	Due to (or as a conse	equence of):									
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Coronary A		Disease	e		· · · · · · · · · · · · · · · · · · ·					
760,	sate be executed thy sician and the burial-transit	cal E		Due to (or as a conse Hypertensi										
687	or Attending Physicien: The law requires that the death certificate be executed that death. Differ death. Differ death. Differ this certificate has been signed by the attending physician and bit estor. After this certificate has been signed by the funeral director. page 2 should be detached for use as the burial-transit in by the funeral director.			. Hypercensi	LOII							+		
Вох	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr							23d. Date o	of deliver.	,	
œ.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregr Other (speci				1	Month	-	ay Ye	ar
0.0	at the	hys	9 🗆 Unknown	9□ Unknown										
ŝ	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con		sulting in the un	derlying caus	e given	in Part I.	23e. Did	obacco u	ise contribu	ite to the	cause of dea	ath?
ord	requi	eted	Myelodysplastic S	Syndrome					_ 10	Yes 2	<b>∑</b> No 3[	] Probab	oly 4 ∐Un	known
3ec	has b	Completed	V						24a. Was	psy	prio	r to comp	y findings av	allable
a	n: Th icate r. pag								1 Yes	ormed? 2∭ No	dea	th? Yes 2	□No	
Division of Vital Records,	nysician: The law nis certificate has I i director, page 2 s	o Be	25. Was case referred to medical examiner?	ospital:					Death (Check only					
ō	I Phy ar this arai d	<b>⊢</b>  -	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of		Injury at	4 Nursin	g Home 5 Resi	dence (	Other (	Specify)		
<u> </u>	nding P ath. r: After e funera	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	Work?	s 2 No			y oddaniod			
<u>NS</u>	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Speci	nome, larm, stre	et, factory, of	fice	-	281. Location (	Street and	d Number o	or Rural F	Route Numbe	<u></u> 3Γ,
ב	ital o	, e							City or To					
	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director: completely filled in by the	cai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knier: On the basis of examinating	owledge, death	occurred at the	he time,	date and pla	ace, and due to the	cause(s)	and manne	er as state	ed.	
	the the mplet	Medical	29b. Signature and title of certifier	and manner stated.					occirod at the time,					
		-		MIM, MD	4		cense n	um <b>per</b>			e signed (N			
3	140	-	30. Name and address of person who con		m 22a) /T 0		284			Febr	uary	19,	2004	
			S.S. Shamin, M.D.				1 1 177	or Sna	ina Mar-	7100-	200	102		
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1			ing, mary	rand	209	UZ		
	Registra	ar	FEB 23 200	14 Sepera	19	Span	Ka	/						

			1 - State Registrar	State of Ma	aryland			nt of He te of D		nd Me		ene g. No. 20	104	07477
	Physici		1. Decedent's Name (First, Middle, Last) Haritun Aslan								2. Date of Death Month February	Day	Year 2004	3. Time of Death 1:05 p M
-	/Medio Examir		4a. Facility Name (If not institution, give standard Hospit					Town, or L				4c. County		ry
1	Funeral Director		215-23-7528	7. Age M 2□F	68	st birthday) Yrs.	If Und Months		If Under 24 Hours	Hrs. 8	B. Date of Birth (Month, Day, July 27,	Year) 1935	9. Birthp Cour Turk	place (State or Foreign htry) Cey
	death with the Maryland me 23s or 28s-f show mant to notified at	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgom	ery	•	Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h with the	Funeral Director	10e. Street and Number 11903 Parklawn Dri	ive, Apt.	204			p Code 20852			10	g. Citizen of V Turk		ntry?
336		by Funer	11. Marital Status	2. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		1			panic Origin , Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)	Blac	e - Amend k, White, White	
Baltimore, Maryland 21215-0036	within 72 hours after ene. than "natural", or ite	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give	kind of w	ual Occupati ork done du use retired)	ion ring most o	f working	7	6b. Kind of Bu		dustry
land 2	ould be filed we Mental Hygie arked other I	To Be Co	12 17. Father's Name (First, Middle, Last) Sarkis Aslan			Custo	)III 1 6				First, Middle, M Pamuk			
, Mary	permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury oc other traumatic as once.		19a. Informant's Name/Relationship (Type Nusaper Aslan / W		not Die	1190	)3 Pa	rklaw		ve,		4, Roc	kv <b>i</b> 1]	Le, MD 20852
timore	rtment of H		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  1 □ Donation 5 □ Other (Specify)		Gate	ce of Dispo	eave ery	ume or other place) Ind Address		ebrua 200	ary 25	oc. Location -	•	ng, Maryland
Ba	Departrice Departrice Importa any inject.	5 13	21. Signature of Funeral Service License  23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	Cole	the death.	Fr. 50	anci O Un	s J. (	Collír Lty Bl	vd.		lver Sp	ring	MD 20901 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	META S  Due to (or as a	STAT	ic	,	NG		NC				Interval Between Onset and Death
8760,	4% 1	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
O. Box 6	death certific a attending p id for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic Other (s	oregnancy specify)			₹ / \ */	23d. Dat Mo	e of delive	ery Day Year
rds, P.	The law requires that the tite has been signed by thoage 2 should be detache		Part II. Other significant conditions conf	tributing to death bu	ut not resul	iting in the ur	nderlying	cause given	in Part I.		23e. Did toba	1/	nbute to th	ne cause of death?
Vital Record		Completed		4					******	_	24a. Was an autopsy perform	ed?	Vere auto prior to con leath?	psy findings available mpletion of cause of No
Division of Vita	iding Physician: Th th. After this certificate funeral director, pag	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatie 28a. Date of Injur (Month, Day	ry :	R/Outpatien 28b. Time of Injury	t 3 [	OA Other 28c. Injury a Work?	4 □ Nursi	ing Home	Check only one  5 Resider  d. Describe hov	ice 6 Oth		x)
Divisi	To the Hospitat or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hon c. (Specify)	me, farm, stre	eet, facto	ry, office		28	If. Location (Stre City or Town,		er or Rura	I Route Number,
	the Hospi iin 24 hour the Funer spletely fill	edicai	29a. Certifier Cartifying Phys (Check only one)	ician: To the best of ar: On the basis of and manner sta	examinate	vledge, death on and/or inv	estigation	n, in my opir	nion, death	place, an occurred	at the time, dat	e and place, a	and due to	the cause(s)
)	V With	×	29b. Signature and title of certifier	Goma	سد	- H	D.		2766				3/06	-1
			30. Name and address of person who col A LPANA GOS WAY  31. Date filed (Month, Day, Year)	Appleted cause of de M/ Y D  32. Begistra	11119	Rock	Print)	E PIK	ie,	ROC	KUI WE	, MD o	20 89	52
0	Sta Regist		FEB 2 4 200		ars signall	9	40	anta	+					

DHMH 17 Rev 1/2001

ASLAN HARITHN A

			1 - For State Registrar	State	e of M	larylan	d / Depa <i>Cei</i>	artmen rtificat			and M	lental		ene g. No. 2 (	004	07478
			1. Decedent's Name (First, Middle,	Last)								2. Date Mont	of Death	Day	Year	3. Time of Death
	Physicia /Medic	_	Ezell				Arey					Feb.	14,	2004		5:36 am <sup>M</sup>
	Examin		4a. Fecility Name (If not institution,	give street an	d number	)		4b. City,	Town, or	Location of	of Death			4c. Count	ty of Death	
			501 Quarry Place							Heig				Prin	ce Ge	orges
	Funeral			i.Sex 1 ☐ M 2			last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date (Mont	h. Dav.	Year)		place (State or Foreign ntry)
T I	Director		434-56-2314			65	115.					May	21,	1938	Loui	siana
and	*		Usuat Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation							1	Od. Inside City Limits
Aaryl	of all	5	Maryland Prince	genro	AC	Can	itol H	eicht	c							1 ☐Yes 2 ☐ No
the	280	ect	10e. Street and Number	60016		Joup	1001 11	10f. Zip					10	g. Citizen of	What Cour	ntry?
with	30 00	٥	501 Quarry Place					207	43				IIn	itad	Stata	s America
deeth with the Maryland	ma 2	Funeral Directo	11. Marital Status	12. Was	Deceden	t Ever in U.	.S. 13.	Was Dece		spanic Ori	gin? (Sp	ecify Yes		14. Re	ack, White,	can Indian,
affer o	흔	교	1 ☐ Never Married 2 ☐ Marrie	d 1 🗆	ed Forces Yes 2.F is, Give			iires, spe 1 □ Yes		Specify:		rticali, et	J.,	Speci		
G Z I Z I 3-0030 filed within 72 hours after	5.0	þ	3 Widowed 4 Divorced	Year	or Dates	:		10103	XI40	эрвспу.				Зрес	"у. ВТ.	ack
7 %	netu dical	Completed	15. Decedent's (Specify only highest	Education grade comple	eted)		16a. Dece (Give	kind of wo	rk done o	turina mosi	t of work	ing	11	6b. Kind of I	Business/In	dustry
ig ig	Je.	id m	Elementary/Secondary (0-12)	Colle	ge (1-4o	r 5+)	Secre	DO NOT u						Inton	ior D	ecorating
19d wi	Hygiene. other then		12 17. Father's Name (First, Middle, Li	ect)			Secre	Lary/	CIEL		er's Name	e /First M		aiden Suma		ecorating
	d of	Be		151/									70070, 111	2.00		
2	I Health and Menial Hygiene. Item 27 is marked other then "natural", or Itema 23s or 28s-1 show other traumatic event. Ite Medical Examiner must be notified at	10	L.C. Taylor	o (Tuno Bria	e)		10b Maili	na Address	(Street a			Jones	Jumher	City or Town	State Zir	Code)
	h and 7 is n		19a. Informant's Name/Retationshi Richard F. Arey/					3								nd 20743
45 E	of Health a litem 27 is r other tra		20a. Method of Disposition			20b. F	Place of Disponentery, crea					Date		Oc. Location		
i s	or o		1 ☑ Bunal 2 ☐ Cremation 3		from Stat	8	emetery cre rt Lin			1	2/2/	/200	/ <sub>1</sub> D	rontra	and 1	Manual and
Saltimor Jermit. Pages	rtant		1 Donation 5 ☐ Other (Special Service Li			10.		2. Name ar				1/200	4 D	rentw	oou, i	Maryland
<b>5 5</b>	Department of H Important: If its any injury or ot pnce.		Man 2	West	h-		3	art b	inge	ln Fu nsbur	nera g Ro	ad Ho	me rent	wood,	Mary:	land 20722
	100		23a. Part1. Enter the disease, or of shock, or heart failure. List o	omplications	that cause	ed the deat										Approximate Interval Between
Ph	nysicían		Immediate Cause (Final disease or condition				c Carc	inoma	Ga1	1b1ad	lder					Onset and Death 6 months
1	Medical		resulting in death)	d		is a conseq										
E	xaminer		Sequentially list conditions	b												
D	75	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Di	ue to (or a	is a conseq	uence of):									
ou, be executed	hysician and he burial-transit	Cam	that initiated events resulting in death) Last	c	ie to (or a	is a conseq	mence of).									
te be ex	cian	al E			20 10 (01 0											
9	physic the	2		d												
_ =	ding se as	/Me	IF FEMALE:	23c. If ye	s, outcom	ne of pregna	ancy							23d. D	ate of deliv	erv
BOX eath ce	atten for u	cian	23b. Was decedent pregnant in the past 12 months?			2 ☐ Feta at time of d		⊒Ectopic p ⊒ Other (s <sub>i</sub>							Month	Day Year
j ₹	y the	Physician/Med	1 □ Yes 2X No 9 □ Unknown	9□	Unknown											
Ords, P	been signed by the attending ph should be detached for use as th	by Pi	Part II. Other significant condition	s contribution	g to death	but not res	sulting in the u	inderlying	cause give	en in Part I	١.	230.	Did toba	acco use co	ntribute to t	he cause of death?
	n sig												1 Tes	s 2□No	3 Prot	bably 4 Unknown
<b>Hecord</b> he law requir	s bee	ojet										24a.	Was an autopsy	24b	. Were auto	opsy findings available impletion of cause of
	age 2	Completed										10	perform		death?	2□ No
		BeC	25. Was case referred to medical							26. Place	e of Deat	h (Check				
00	direc	TOE	examiner? 1 Yes 2 No	Hospital:	1 🗌 Inpa	itient 2	ER/Outpatie	nt 3 D	Oth	er: 4 □ Nu	ursing Ho	me 5🛚	Resider	nce 6 🗆 O	ther (Specia	(y)
			27. Manner of Death 1 SNatural 5 Pending	28a.	Date of In (Month, I	jury Day Year)	28b. Time of Injury	of	28c. Injun Work	/ at k?		28d. Des	cribe hov	w injury occu	urred	
VISION	death. ctor: Al y the fu	atle	2 Accident investig	ation				М	10	Yes 2						
		Certification	3 Suicide 6 Could no 4 Homicide determin		Place of I building,	Injury - At h etc. (Speci	ome, farm, st fy)	reet, factor	y, office				tion (Stri or Town,		nber or Rur	al Route Number,
oital C	erel D		29a. Certifier 1 X Certifying	Physician:	To the be	st of my kno	owledge, deal	th occurred	at the tin	ne. date ar	nd place.	and due t	o the car	use(s) and n	nanner as s	stated.
UI To the Hospital or	n 24 hours after de na Funerel Direct bletely filled in by t	edical	(Check only 2 Medicel E	xaminer: On		of examina										
Toth	within 2 To the complet	M	29b. Signature and title of certifier	^	1	1	1.	29	c. License	e number			29	d. Date sign	ed (Month,	Day, Year)
'	(		1 Molin 2	·VV	10	Hn	-9MA	M	)	D240	)52			Feb.	18, 2	004
	141	/	30 Name and address of person v					and the same of th								
_	$\bigcirc$		John E. McKnight	, M.D.			ing St	., NW	, #2	200,	Wash	ningt	on,	D.C. 2	20010	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	4 /4	JZ. FIBGII	strar's Sign	Local	21								

			1 - For State Registrar	State of Mar	yland / Depa <i>Cel</i>	artment of H	lealth and <b>I</b> Death		giene 20	04	07479
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Gene Stevens	Aldous		-		2. Date of Dea Month Februa		Year 1	Time of Death 0:30 P M
	Examir	_	4a. Fecility Name (If not institution, give s Casey House Hosp			Rockv			_1	gomery	
	Funeral Director		217-20-0707	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) June 2,	y, Year)	Country)	(State or Foreign orado
	Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom		Oc. City, Town or Lo						nside City Limits I ☐ Yes 2 🎇 No
	with the a or 28s	Director	10e. Street and Number 10100 Watkins Roa	d		10f. Zip Code	0882		10g. Citizen of W	hat Country? State	c
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itama 23a or 28a-1 show say injury or other traumatic event, the Medical Examinet must be notified at once.	by Funerai		12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		- American Ir c, White, etc.	ndian,
21215-0036	d within 72 hou piene. r than "nature the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired Teacher	ation during most of wor t)	king	16b. Kind of Bus		y 1 System
Maryland 2	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Shaler Eurgene	Aldous			Iris	Stev			
	and 2 sho lealth end I m 27 Is ma		19a. Informant's Name/Relationship (Ty) Ann H. Aldous	pe, Print) (Wife)	101	ng Address (Street .00 Watkin	ns Road,	Gaither		ary1an	d 20882
Baltimore,	permit, Pages 1 Department of H Importent: If ite sny injury or ot once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		the state of the s	ike Crema: Name and Addre Rapp Fund	tory 20	Crematio	Be1tsv	<b>il</b> le, 1	Maryland
8760,	Physician /Medical Examiner  bhysician and physician and street is the purial transit	dicai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Advanced  Due to (or as a	Gastric (consequence of):					Inte	oroximate mval Between set and Death Months
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other <i>(specify)</i> _			23d. Date Mon	of delivery th Day	Year
م	quires that the signed by aid be detact	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		obacco use contri /es 2 🔀 No		use of death?
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed						24a. Was autop perfo	rmed? pr		indings available tion of cause of No
ion of Vita	Attending Physicien: Th r death. ector: Atter this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	dospital: 1 [] Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Injur Wor	er: 4 🗆 Nursing H		ne) dence 6 XOthe now injury occurre		Hospice
Division	or At fter o jirec in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y · At home, farm, sti (Specify)	reet, factory, office		28f. Location (5 City or Tow	Street and Numbe vn, State)	r or Rural Rou	ite Number,
	To the Hospitel or At within 24 hours after or To the Funarel Direct completely filled in by	edical		sician: To the best of ner: On the basis of e and manner state	xamination and/or in						
į	To the within to the comp	Me	29b. Signature and title of certifier	the		29c. Licens	1218		29d. Date signed 2 / 1 (	(Month, Day,	Year)
/	(12)		30. Name and address of person who co Charles Michael H	empleted cause of dea	ath (Item 23a) (Type, M.D.; 600	Print) S. Frede	rick Ave	., Gaith	ersburg,	Md. 2	0877
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 8 2004	2. Registrar	s Signature	K					

State of Maryland / Department of Health and Mental Hygiene 07480 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vasi **Physician** Ernestine Alexander February 22, 2004 11:10 a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner 6810 Painter Terrace Prince George Capitol Heights If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days 1 □ M 2 X F Hours 1Ó, 1931 Alabama 73 Jan. Director 416-40-8669 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a, State 10b. County 10c. City. Town or Location ms 23a or 28e-f show 1 No 2 No Director Prince George Capitol Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 6810 Painter Terrace 20743 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "natural", or Iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 9 3 Widowed 4 □ Divorced **Black** Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 +1Teacher Assistant PG Co. School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mattie Parker Will Walker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Painter Terrace Capitol Heights, Md. 20743 Audrey Elaine Walker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. Mar. 2,2004 Cheltenham, Maryland 22 Name and Address of Facility Alexander S. Pope Funeral Home 5538 Marlboro Pike Forestville, Md. 20747 21. Signature of Funeral Service Licenses vette Kr Approximate Interval Between Onset and Death 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Multiple myeloma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the β as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown been signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? page certificate 2 🗔 No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be 1 ☐ Yes 🗶 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: the Hospital or Attending 5 Pending investigation after death.

Diractor: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only опе) and manner stated and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Wade Fletcher, 1050 W.Perimeter Road Andrews AFB, Maryland 20762 2. Registrar's Signature 31. Date filed (Month, Day, Year State FEB 2 4 2004 Registrar

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrer Certificate of Death Reg. No. 2004 07481
	Physici	an	1. Decedent's Name (First, Middle, Last)  Etta Clarine Butler Allen  2. Date of Death Month Day 02/21/2004 1:45 aM
	/Medic	al	
	Examin	er	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)
	Director		
	land ow		Usuel Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
_	Mary a-f sh	tor	MD Prince Georges Fort Washington <sup>1⊠Yes 2□No</sup>
A.	ours after death with the Marylar rat', or Itams 23a or 28a-f show	Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  20744
4	sath w	eral	1002 Talmer Ret apt., U.S.A.
4,0	Iter de	Fun	Armed Forces?  If Yes, specify Cuban, Mexican, Pueno Rican, etc.)  Black, White, etc.
21215-0036	72 hours after death w "naturel", or Items 23e odical Exeminar must	by	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2€☐ No Specify: Specify: Black
5-6	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
(a) 12 12 12 12 12 12 12 12 12 12 12 12 12	i withii iene. r than	omp	Elementary/Secondary (0-12) College (1-40r5+) 11 Chef Manager Private
		BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ira Ma	P_	Jeremiah Jefferson  Bertha Cribb
N N	id 2 sh ith and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)  Rayna Robert Allen/Husband 1002 Palmer Rd.apt#4 Ft. Wash, MD 20744
	s 1 and of Health item 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Baltimore.	Page ment ant: If ury or		1 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify)  Resurrection Cem. 2/26/2004 Clinton, Maryland
Ball ()	permit. Pages I and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. once.		21. Signature of Funeral Service Licensed  22. Name and Address of Facility Taylor; s Funeral Home 1722 N.Capitol St.NW Washington, DC 20001
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Open and Death of the cause of the card Death of th
	Physician		Immediate Cause (Final disease or condition
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):
	Examine:	-a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying
	uted d ansit	Examiner	cause. Enter Underlying Cause College of Injury that initiated events  c.
760.	te be executed ysicien and e burial-transli		resulting in death) Last Due to (or as a consequence of):
6876		dical	d
⊥ ×	n certif inding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
1	The law requires that the death certification because the stending phase is should be detached for use as the	by Physician/Med	1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year
E a	that the ded by the	Phy	9 Unknown  Part If Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.  23e. Did tobacco use contribute to the cause of death?
1 0	luires tha	d by	Renel Kailure 1 Yes 26No 3 Probably 4 Unknown
Ital Records	aw requi	ompieted	24a. Was an autopsy findings available prior to completion of cause of
) a		Com	performed? death?  1 \( \text{Yes}  2 \text{No} \)  1 \( \text{Yes}  2 \text{No} \)  1 \( \text{Yes}  2 \text{No} \)
Y. ita	ysician: The Is certificate hi director, page	Be	25. Was case referred to medical examiner?  Hospital:   Continued to the c
4	ਵ ਦੁਸ਼ੁ	7: To	27. Magner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred
Vision	ttending R death. stor: Alter	atio	in Section (Month, Day Year) Injury Work?  2 □ Accident investigation M 1 □ Yes 2 □ No
二 二 Sign	25.50	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2	Hospital 24 hours a Funeral I		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(')	the the	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To To	~	29b. Signature and title of pertifier  29c. License number  29d. Date signed (Month, Day, Year)
	9/		30. Name and address of person who completed says of death (Item 29a) (Type, Print)
_	' 2		11701 LIOCHSTON Kd Ff WASTINGTON, Md
	Sta Registr		31. Date filed (Month, Day, Year)  SER 2 6 2004

			1 _ State	State of M	laryland		rtment of H		d Mental Hy	giene Reg. No. 2	004	07482
		* 6	1. Decedent's Name (First, Middle, Last)				inouto or z		2. Date of Dea	ath		3. Time of Death
e.	Physicia		LOUIS VINCENT	BARAZO	OTTO				FEBRUA	RY <sup>Day</sup> 10	2004	12:31P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give st				4b. City, Town, or	Location of D			inty of Death	
	Examin	eı.	Frederick Memori				Frederi	ck			Freder	ick
	Funeral		5. Social Security Number 6. Sex	7. 4	ige (In yrs. la	ast birthday)	If Under 1 Year Months Days		Ain. (Month, Da	v. Year)	9. Birth	place (State or Foreign ntry)
E <sup>2</sup>	Director		050-01-9773	M 2□F	8	36 Yrs.	Monard Days	1,00.0	Feb. 12	, 191	7 New	York
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation				Т	10d. Inside City Limits
	anyla shov	ž		•								1 XYes 2 No
	he M	Directo	Maryland Frederic  10e. Street and Number	K	Fr	rederio	10f. Zip Code			10a. Citizen	of What Cou	ntry?
	with a or	٥	30 North Place				21701			1	U.S.A.	
	ns 23	Funeral		2. Was Deceder	at Ever in U.S	S. 13. V	Vas Decedent of Hi	spanic Origin	? (Specify Yes or No-	14.1	Race - Amer	
	ter d	Fun	1 Never Married 2 Married	Armed Forces	3?		Yes, specify Cubai	n, Mexican, Pi	uerto Rican, etc.)		Black, White	, etc.
8	urs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		I□Yes 2\\X\\	Specify:		Spe	<sup>ecify:</sup> Whi	te
2-0036	within 72 hours after death with the Maryland ene than "natural", or items 23a or 28a-f show the Meulcal Evantinar must be notitled at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	lent's Usual Occupa	during most of	working	16b. Kind o	of Business/Ir	ndustry
2121	e e e e e e e e e e e e e e e e e e e	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT use retired,	)		D 1	1.0	
N	filed wi Hygien other th	Con		1			Painter	10 Mathada	Name (First, Middle,			vernment
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan the Hall and Meantal Hygiene at the first is marked other than "natural; or thems 23a or 28a-f show other traumatic event, it a Meulcal Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) Adolf Buchignani						rine Cheic		narrie)	
<u> </u>	2 should be and Mental I is marked o	2		o (Print)		10h Mailie	n Address (Street		r Rural Route Numbe		wn State Zi	n Code)
Mai	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Type Richard Barazotto						e, Chuchto			
o,	1 and 2 Health em 27 ther to		20a. Method of Disposition	(5011)	20b. Pi	lace of Dispo	sition (Name of	1	Date		on - City or T	
و	ages nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from Stat			natory or other place S. Cath. Ce		21/04	Frede	rick.	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 900.00.		21. Signature of Funeral Service Licence	9	1.00			1				
Ba	Depa Depa Impo any id		1 Ruts	020	H	RO	DBERT E. 1 PO1 NORTH	DAILEY MARKET	& SON FUN	ERAL I	HOMES,	P.A. 21701
			23a. Part 1. Enter the disease, or complic	ations that caus	ed the death							Approximate Interval Between
0.5	Physician	ğ li	shock, or heart failure. List only one Immediate Cause (Final			h 0	tona Dire	ic one	1.4.6		ļ	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	s a consequ	uence of):	inal acrit	110000	acid suc			M(M) 1-3
	Examiner		Sequentially list conditions b.									
	D. E	ner	if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequ	uence of):						
	nd ransi	Examiner	Cause (Disease or injury that initiated events c.									
Ö,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or a	is a consequ	Jence or):					1	
8760,	ate b	dlcal	d.									
Box 6	ertifica Jing pt	/Med	IF FEMALE:	Sc. If yes, outcon	ne of pregna	nev				234	Date of dein	2001
Во	eath certifi attending I for use as	lan	in the past 12 months?	1□Live birth 4□Pregnant	2 Fetal	death 3	Ectopic pregnancy Other (specify)			230.	Month	Day Year
P.O.	the de	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown		Jan 0 L	- Ottlo: (Spoony)					
	res that the de signed by the a I be detached f	/ Ph	Part II. Other significant conditions con-	tributing to death	but not resu	ulting in the u	nderlying cause give	en in Part J.	23e. Did to	obacco use o	contribute to	the cause of death?
ds	uires sign id be	d by	chronic Atrial	fibrid	atim				101	res 2 PN	0 3 □ Pro	bably 4 Unknown
Records,	w requir been si should	Completed	Adult onset d	saseter	mel	Citos			24a. Was	an 2	4b. Were aut	opsy findings available empletion of cause of
Be	he lav e has	шć	Hypertension						autop perfo	rmed?	prior to codeath?	
ā	icien: Th certificate rector, pag	e C	25. Was cast referred to medical					26. Place of	Death (Check only of		10100	20110
>	Physicien: The this certificate hirral director, page	To B	evaminer?	ospital:	itient 2 12	ER/Outpatier	t 3 DDA Othe	0.5	ng Home 5 Resid		Other (Spec	(fy)
To C	g Physier this		27. Manner of Death	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of	28c. Injun	y at k?	28d. Describe h	now injury oc	curred	
ō	ath. r: Af	atlo	1 Patural 5 Pending Investigation				M 1 🗆 '	Yes 2 ☐ No	-			
Division of Vital	r Atto	Certifloation:	3 Suicide 6 Could not be determined		Injury - At ho etc. (Specify		eet, factory, office		28f. Location (S City or Tox		umber or Ru	ral Route Number,
	ital or saf					4.4.4.4.4		= = 17	alone and due to the			-t-t-d
	Hosp 24 ho Fune fely fi	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	er: On the basis	of examinat	tion and/or in	vestigation, in my of	pinion, death o	occurred at the time,	date and pla	ce, and due	to the cause(s)
	To the Hospital or Att inding Ph within 24 hours after dealh. To the Funeral Director: After it completely filled in by it e funeral	Med	29b. Signature and title of certifier	)			29c. License	e number		29d. Date si	gned (Month	. Day, Year)
)	F 3 F 0		1 - Janua L.	eenl	en	~ <u>`</u>	D2	2840-		2-1	2-04	
	5		30. Name and address of person who co	mpleted cause of	f death (Item	1 23a) (Type.	Print)	. 1 1				
	9	100		essler	M.D.	Pa	2 BOX 20	MIDI	DIETOUN,	MO.	217	69
3	Sta		31. Date filed (Month, Day, Year)	11	strar's Signa	ture :	directly to					
	Regist	rar	FEB 2 0, 20	JU4 /	No.	AF A	Tribanda.					

	1 - For Amend Item #5 Registrar  1. Decedent's Name (First, Middle, Last)			uncate Of	Dealin	2. Date of D		. <u> </u>	3. Time of Death
Physician						Month	Da		
/Medical	Margaret  4a. Facility Name (If not institution, give	R. Beall		4b. City, Town, o	or Location of D	Februa		0. 2004 County of Death	10:00 P <sup>M</sup>
Examiner						outil			
uneral	Gilchrist Cente: 5_Social Security Number 6. Sex		last birthday)	Baltimo If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth .	Baltimon 9. Birth	nplace (State or Foreign
rector	5. Social Security Number 5.77-36-5046	M 2 <b>X</b> )F 76	Yrs.	Months Days	Hours	Min. (Month. L Sept.			arvland
LEA	Usual Residence of Decedent								
If item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits 1 ▼Yes 2 □ No
be notified Director	Maryland Carrol	1	Mount			- *			
Dire	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Co	untry?
ral	5 West Church S	treet 12. Was Decedent Ever in U	S 42.1	2177		1/Canada Van as h		U.S.A.	ioon Indian
Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married	Armed Forces?  1 Yes 2 XNo	.5.	f Yes, specify Cub	an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0-	Black, White	
by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2\X\No	Specify:			Specify:	
P	15. Decedent's Edu	cation		dent's Usual Occup			16b. F	(ind of Business/	<u>nite</u> ndustry
t, the weaten	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			
E O	9	College (1:401 54)	Home	emaker			0	wn Home	
Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middl	e, Maidei	n Sumame)	
7 B	Richard Howard				Es	ther Ear	P		
5 .	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number o	r Rural Route Num	ber, City	or Town, State, Z	ip Code)
	Dorothy Hill - Daug			4.1	ods Roa	ad, Fred	-		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	1 0	Place of Dispo cemetery, crer	sition (Name of natory or other pla	сө)	Date	20c. L	ocation - City or 1	Town, State
	4 □ Donation 5 □ Other (Specify)		thesda	Meth. Ce	emetery	2/16/04	Dam	ascus, M	laryland
once.	21. Signature of Fun ral Service License	00)	) 0	Name and Addre	ss of Facility	th P.A.,	Fune	ral Home	
a	23a. Part1. Enter the disease, or compli	William	1			-			20872 Approximate
	23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyl	ng, such as car	diac or respiratory	arrést.	ary rand	Interval Between
an	Immediate Cause (Final disease or condition	CORONAMY	ARTES	24 disease	se				Onset and Death
al	resulting in death)	Due to (or as a conseq	uence of):						3
er	Sequentially list conditions		com seu						
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				_		
			,,.						
dic		J							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d. Date of deli	very
Dhysician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnanc Other (specify) _	у			Month	Day Year
hysi	9 Unknown	9□ Unknown							
by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
leted t						1	Yes 2	!□No 3□Pro	obably 4 Inknown
Completed						24a. Wa		24b. Were au	topsy findings available ompletion of cause of
Com						per 1 ☐ Yes	opsy formed? 2© No	death?	2 No
5 0	25. Was case referred to medical				26. Place of	Death (Check only			
, , ,	examiner? 1 Tes 2 S No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	it 3□ DOA Oth	ner: 4 🗆 Nursin	ng Home 5 ☐ Res	sidence	6 We ther (Spec	in hospice
	27. Manner of Death  1. SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo		28d. Describe	how inju	iry occurred	
atic	2 Accident investigation			M 1	Yes 2 □ No				
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str by)	eet, factory, office		28f. Location City or To			ral Route Number,
ပိ									
completely filled in by Medical Certiff	29a. Certifier (Check only one)  29a Certifying Physical Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, deat ition and/or in	n occurred at the til vestigation, in my o	me, date and p opinion, death o	lace, and due to the occurred at the time	e cause(s , date an	s) and manner as id place, and due	stated. to the cause(s)
Med	29b Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Da	ate signed (Month	. Dav. Yearl
	While and	mo		2	7303			RUNRY	
		employed across of death (**	n 22a\ (T -		4000		V		7
		DINDIBLEG CAUSE OF DEATH (ITEM	⊓ ∠Ja) (1yp <u>e</u> ,	EGHU _				III-D-1000 Para III.	
0	30. Name and address of person who co	mg 6601	VI. (	herels S	it Bal	hmore w	0 Z	15021	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Brady 20, 2004 2:48 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □XF Director 213-16-2601 84 Sept. 15, 1919 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. or Items 23a 1071 Loving Road 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercition 2008. 1 ∐Yes 2 MaNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White À 3 

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Mills Annie Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Miller/ Daughter Loving Road, Severn, Maryland 1071 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Donation 5 □ Other (Specify) 2/25/2004 Arlington, Virginia Arlington National 21. Signature of Length eral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEOMONIA DAY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 4 Unknown 1 Yes 2 No 3 Probably this certificate has been signal director, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide pelli K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39037 30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) AAMC m (TC)+ ELC ANN APOCIS 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registrar FEB 2 3 2004

		For State Registrar	State of Maryla		artment of F		Mental Hygier Reg. N		0748
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La Rober + Z 4a. Fecility Name (If not institution, gi	Brown e street and number)	1 (tr	4b. City, Town, o	r Location of Death	Month 0 2 19	Day Year 4 200 + 4c. County of Death	
Funeral Director		5. Social Security Number 6. 390-20-8377 Usuel Residence of Decedent	- 1	:. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	nne Arund 9. Birth Coul 1926 Mich	place (State or Foreign
th the Maryland or 28a-f show	Director	10a. State 10b. County  Maryland Anne Aru  10a. Street and Number		ity, Town or Lo	10f. Zip Code		10g. (	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No intry?
be filed within 72 hours after death with the Maryland nial Hyglene. ad other than "natural", or fleme 23a or 28a-f show event. It a Mucilcal Examinat must be notified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 57 Yes 2 □ No WW If Yes, Give Year or Dates:	U.S.   13.	21401 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 \$\frac{1}{2}\$ No	lispanic Origin? (Si an, Mexican, Puerto Specify:		14. Race · Ameri Black, White Specify: Wh	can Indian, , etc.
within 72 ho lene. r than *naturi	ompleted	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of world)	king	Kind of Business/Ir	ndustry
2 should be filed and Mental Hygis is marked other raumatic event.	Be	17. Father's Name (First, Middle, Las Raymond Zanes Bro	v) wn			18. Mother's Nam Marie Fas	ne (First, Middle, Maid	en Sumame)	n Code)
permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.	100	19a. Informant's Name/Relationship Barbara D. Brown  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	/ Spouse  20b.  Removal from State  (fy) Cro	Place of Dispo cemetery, crea wnsvil	Cherry Ro position (Name of matory or other place le Vet. C 2. Name and Addre	ad Annap	Date 20c.	yland 214 Location - City or T ownsville lor Funer	01 own,State , Maryland al Home, I
Physician // Medical Examiner and the private	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. My lody Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	Mye equence of): 4 S p l a S equence of):	loma				Approximate Interval Between Onset and Death
that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc; □ Other (specify) _	y		23d. Date of delive Month	rery Day Year
The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.	1 🗆 Yes		the cause of death? bably 4 □Unknow
	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy performed 1 Yes 2 1 th (Check only one)	prior to co	opsy findings availab ompletion of cause of 2 No
ding Phys	To B	examiner?  1 Yes 25 No  27. Manner of Death  1 Natural 5 Pending investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injui	ner: 4 🗆 Nursing H	ome 5 Residence 28d. Describe how in		ify)
irec irec	ai Certification:		building, etc. (Spe			e(s) and manner as	stated.		
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29b. Signature and title of certifier  29b. Name and address of person wh	uminer: On the basis of examinand manner stated.  A - Completed cause of death (It	~ N	29c. Licens	se number )59173	29d. [	Date signed (Month)	Day, Year)
Sta Regist			32. Registrar's Sig	00 Bes	togate !	Ed, Swit	e 300, Ans	napolis	MD 21

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22 2004 February 7:52 A JOAN P. BRYAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Chrles 168 Wood Duck Circle La Plata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 27 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 1944 Maryland 59 214-42-1796 Director Usuel Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location 'natural', or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at La Plata Yes 2 No Charles Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 168 Wood Duck Circle USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If tiem 27 is marked other than "naturel", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Violet Bryan William Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17647 Wild Cherry Lane King George, VA 22485 Heather E. Polcznski (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny Injury or once. 0 Alexandria, VA 2-24-04 Metropolitan Crem. 22. Name and Address of Facility Eberwein Funeral Services 21. Signature of Funeral Service Licensee M00173 4433 White Pls. la. White Pls., MD 20695 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cograce /Medical Due to (or as a consequence antely disease **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of or Attending Physicien: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physicien IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 2**X** No 1 ☐ Yes uneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23125 February 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6502 Kenilworth Ave. #100 Riverdale, MD 20737 Madhu K. Mohan, M.D. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State FEB 2 2004 5 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 12, 2004 **Physician** 3:13 AM Lucy Estelle Boothe /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center 8. Date of Birth (Month, Day, Year) 9. Birthpiace (S Country) June 13, 1911Mary Land If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗓 F 92 Yrs. 217-74-3948 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner mant be notified at 1 ☐ Yes 2X No Great Mills St. Mary's Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20634 21929 Chancellors Run Road "natural", or Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural', or Item any injury or other traumatic event, the Wedical Examiner 900. 1 Never Married 2 Married White 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Lucy Estelle Abell George Edward Combs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 134 Compton, MD 20627 Robert Wallace/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/16/2004 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, MD Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer eprice Licensee 22 Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each-line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequer Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delig 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month detached for 5 ☐ Other (specify) ☐Yes 2 No 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ፟ No 26. Place of Death (Check only one) Other: 1 Inpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 FR/Outpatient within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Injury 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Dr Patrick J. Jarbbe, MD 24035 three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 13 2004 Registrar

DHMH 17 Rev 1/2001

BUCKLER

THEODORE

HOWARD

State of Maryland / Department of Health and Mental Hygiene 2004 07489 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 22, 2004 February **Physician** William Augustus Burch, Jr. 1:20 AM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall 30185 Charlotte Hall Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1**X**M 2□ F 60 Yrs Maryland 216-40-7474 Director March 12, 1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ?7 is marked other than "natural", or Iteme 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√No Charlotte Hall St. Mary's Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30185 Charlotte Hall Road 20622 USA Completed by Funeral death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examina ☐Yes 2XNo fYes, Give 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Parcel Service Truck Driver 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eileen Clarke William Augustus Burch, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30185 Charlotte Hall Road, Charlotte Hall, Maryland 20622 Margaret Mary Burch/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 24, 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Queen Of Peace Cemetery Helen, Maryland 2004 21. Signature of Funeral Service L 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. michael Noun P.O. Box 270, Leonardtown, Maryland 20650 Part1. Enter the disease or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) small cell lung lancer **Physician** Extensive 3 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consuguerice of) Examiner The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 2 🗆 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 1 No 1 Yes 2 No 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier · Attending oncologist 2/23/04 6 Sudon D50626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sm LEUNAR DTONN MD 20 650 25500 GUPDETP. S. IH HABICA POINT LOOK OUT ROAD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 17490 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2004 4:37 p.m. Mathews Bond February 19, /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 € M 2 □ F 62 Director 220-38-2037 April 7,1941 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County rai', or items 23a or 28a-f ahow Examiner roust be notified at 1 ☐ Yes 2 No Director Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20653 United States 21605 Liberty Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Rever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 10 is marked other 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental Mary C. Spears John H. Bond 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) : If item 27 is Brian U. Woodland / Son 39367 Wood Duck Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2-27-2004 Lexington Park, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Heart 21. Signature of Juneral Service Linesee
Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1140 40 Minus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** water lun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day be detached for in the past 12 months? 5 Cher (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 2 No 1 ☐ Yes 2 10 NO 1 🗆 Yes Drem St. Mary's Hospital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Diffipationt Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? completely tilled in by the tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After P Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number フロハフ 5th O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sam Tellawi, M.D., 703 Surratts Road, Clinton, Maryland 20735 2004 32. Regi grar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 For State Registrar	State of Maryland / De	epartment of Health and I Pertificate of Death	Mental Hygie		<b>a</b> 1
	Physic /Medi Exami	ical	Decedent's Name (First, Middle, Last)     Elizabeth Estelle     Aa. Facility Name (If not institution, give s	Burroughs	4b. City, Town, or Location of Deat	2. Date of Death Month February	Day Year 24, 2004 5:40A  4c. County of Death	
3	Funeral	۳	20485 Waterloo Lar 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Colton Point  ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min	8. Date of Birth	St. Mary's  9. Birthplace (State or Fore Country)	sign
	with the Maryland a or 28e-f show		Usual Residence of Decedent  10a. State  10b. County  Maryland St. Mary	10c. City, Town or	Location	Aug. 16,	1913 Virginia  10d. Inside City Lim 1 □ Yes 2 🎗	
	death with the	eral Director	10e. Street and Number 20485 Waterloo Lane		10f. Zip Code 20626	U	. Citizen of What Country?	
9003	or ite	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:</li> </ol>	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	od within 72 hours giene. er then "naturel". . tre Medical Ex	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (G. life College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of won a. DO NOT use retired)  eacher	king	b. Kind of Business/Industry	
Maryland	s 1 and 2 should be filed within 7: f Health and Mental Hygiene. Item 27 is marked other than "n other treumatic event, the Mesti	To Be (	17. Father's Name (First, Middle, Last)  Radford Bennett R  19a. Informant's Name/Relationship (Type	anson	18. Mother's Nam	e (First, Middle, Mai celle Fitz	den Sumame) gerald	
	ges 1 and 2 sold of Health are if item 27 is or other treu		John M. Burroughs  20a. Method of Disposition  1 MBurial 2 Cremation 3 Re	/ Husband P.O	. Box 44, Colton Po	int, Mary		
Baltimore,	permit. Pages Department of Importent: If I any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses	Charles	Memorial Gard.02/2 22. Name and Address of Facility Bri 22955 Hollywood Roa	nsfield F	onardtown, Maryland uneral Home, P.A. dtown, MD 20650	<u>1</u>
	Physician /Medical		23a. Part1 Enter the disease of complic shock, or heat allure. List only one immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not e e cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death  Month	3
760,	re be executed ysician and burial-transit eburial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause there underlying that initiated events resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 687	It the death certifica by the attending ph tached for use as th	Physiclan/Medlo	J. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
Records, F	w requires tha been signed should be del	by	Part II. Other significant conditions conti	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 No 3 Probably 4 Unknow	'n
		e Completed	25. Was case referred to medical		00 Blood 4 Double	24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No	
of	ing Phys	atlon; To B	examiner? 1 Yes 25 No Ho 27. Manner of Aath 1 Stratural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 ER/Outpatic 28a. Date of Injury (Month, Day Year) Injury	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	me 5 residence 28d. escribe how in	6  ☐ Other (Specify) ijury occurred	
=	7 5 5 5	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, Sta		
	the H	Medical	29a. Certifier (Check only one)  1□ Certifying Physic 20 Medical Examine 29b. Signature and title of certifier	cian: To the best of my knowledge, dealer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)	
(	40		I Clara X	pleted cause of death (Item 23a) (Type	29c. License number  200 5 7 9 8 3	29d. E	Date signed (Month, Day, Year)  2/24/04	
	Sta				t Road, Leonardtown	, Marylan	d 20650	
nd or	Registr	ar	red 2 0	COURT DESCRIPTION OF				

			. For	State of Maryla	and / Depa	artment o	of Health and	Mental Hyg	jiene	
			1 - State Registrar		Cei	tificate (	of Death		leg. No. 200	
H	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day Ye	
	/Media		Mabel Christina Be			4b. City, Tov	vn, or Location of Dea	<u> Februar</u>	y 21, 200 4c. County of E	74
			Asbury-Solomons Is						Calvert	
	Funeral Director		5. Social Security Number 6. Security Number 1 C	7. Age (In yi	s. last birthday) Yrs.	Months D	ear If Under 24 Hrs ays Hours Min		Year) 1905 V	Birthplace (State or Foreign Country) irginia
	and *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryli	tor	MD Calvert		Solomon	s Islai	nd			1 ☐ Yes 2 No
	or 284	Director	10e. Street and Number			10f. Zip Co	de		l0g. Citizen of Wha	Country?
	s 23a	eral	11750 Asbury Circl	e 12. Was Decedent Ever in	US 13 V	20688			Inited Sta	ates Umerican Indian,
9	iges 1 and 2 should be itied within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other fraumatic event, the Macinal Examines required at	y Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	1	f Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	to Rican, etc.)	Black, V	Vhite, etc.
Maryland 21215-0036	hours tural,	ed by	3  Widowed 4  Divorced  15. Decedent's Edu	Year or Dates:	16a. Deced	ient's Usual O	ccupation		16b. Kind of Busine	vhite ess/Industry
215	thin 72 9. an "na Maxiir	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work de DO NOT use re	one during most of wo	rking		•
2	filed will Hygien ther th		12 17. Father's Name (First, Middle, Last)	2	Teac	her	18 Mother's Na	me (First, Middle,	Education	1
anc	d be fi	To Be	Benjamin Evans					_ouise Pa	,	
aryl	shoul and Mari	F	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ig Address (St	reet and Number or R			e, Zip Code)
∑ ``	and 2 lealth a m 27 ls		Janis M. DePuy-dau	ghter	11740 Place of Dispo				Solomon	s Is. 20688
nore	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ F	emoval from State	cemetery, crer	natory or other	place)			
Baltimore,	그 본론증		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		22	. Name and A	tery 02-2		uitland,	Maryland
Ö	Depa Impo Impo eny ii		Hack Allily	5 MO1246		Huntt F P.O. Bo	Funeral Hom x 156. Wal	ne Ldorf. MD	20604-01	56
B			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the de ne cause on each line.	eath. Do not ent	er the mode of	dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	NIA					5-60441
	Examiner		Sequentially list conditions		equence on).					
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	te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
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68	artifical ing ph	Medi	IF FEMALE:				-			
Вох	death certificate attending phy of for use as the	hysician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	tal death 3	Ectopic pregna			23d. Date of Month	delivery Day Year
P. O.	that the death ed by the atter detached for	hyslo	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9 Unknown		(0,000)	/			
o, O	Se Go	<b>by</b> P	Part II. Other significant conditions con	_	-		given in Part I.			e to the cause of death?
Vital Records,	w requir been si should	eted	ORGANIC BA	18 12 3 4 1º	grom E			1 🗆 Ye	7	Probably 4 Unknown
Rec	has has	Completed						24a. Was a autops perform	y prior ned? death	autopsy findings available to completion of cause of
ital		e)	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only on	7	'es 2□ No
	y S	To B	1 Tes 2 No	lospital: 1   Inpatient 2					ence 6 Other (S	pecify)
o uo	ding P h. After I funera	tlon:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe				28f. Location (St City or Town		Rural Route Number,
ā	oital or urs afte aral Dir			1				<u> </u>		
	e Hospital 24 hours a Funeral a etely filled	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my k ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in r	ny opinion, death occu	e, and due to the ca irred at the time, d	ause(s) and manner ate and place, and o	as stated. fue to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1 1		29c. Lic	cense number	2	9d. Date signed (Mo	onth, Dey, Year)
7			1 C/2 H/2/2	521 m		$\Box$	126358		F 15.2.	3,2004
X	RIN		30. Name and address of person who co	Impleted cause of death (It	em 23a) (Type,	Print)	126358 net Fre	DFRICE	Mi) -	20678
0	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Sig	nature		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 -/(		, 5
	Registr	ar	FEB 2 4 2	304 Magaza	1. 1.	needs?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 07493

		•	1 - State Registrar				Cei	rtificate	e of D	eath	,	Reg. No		0145
			1. Decedent's Name	1		2					2. Date of De Month	aath Da	y Year	3. Time of Death
	Physicia /Medic		Raymo	nd S		Brow	24				Feb	21	2004	2:45 PM
1	Examin		4a. Fecility Name (If	-		er)		4b. City,	Town, or L	ocation of Deat	h		. County of Deeth	
I			401 Links	View Dr				_	rstov			V	lashingto	
ļ	Funeral Director		5. Social Security Nu 213-24-92	.07	x XM 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 Hrs Hours Min.		ay, Year)	9. Birthp Cour	place (State or Foreign htry)  MD
	and w	ŀ	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					1	10d. Inside City Limits
	Maryl f sho	ō	MD	Washingto	าท	На	agersto	wn						1 ☐ Yes 2 🔯 No
	28a-	ect	10e. Street and Num				801000	10f. Zip	Code			10g. Cit	izen of What Cour	ntry?
	with Be or	0	401 Links	View Dr	ive			21	740			U	JSA	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23e or 28e-1 show other traumatic event, the Medical Examinations in cutilisatian.	/ Funeral Director	11. Marital Status		12. Was Decede Armed Force 1 Tes 2 If Yes, Give	es?		Was Deced	ify Cuban,	panic Origin? (S Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh:	etc.
Maryland 21215-0036	nours	d by	3		Year or Date	98:					<del></del>			<del> </del>
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2	withir no. then	d L	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)	Meat					T-	bood	
N	Hygie ther nt.		17. Father's Name (	First, Middle, Last)			Heat	Curte		8. Mother's Na	me (First, Middle			
an	d be annual	o Be	Irving W.							Pauli	ne A. Ro	bert	S	
2	should be nd Mental marked c	ဥ	19a. Informant's Na		ype, Print)		19b. Mailir	ng Address	(Street and	d Number or R	ural Route Numb	er, City o	or Town, State, Zip	Code)
<u>æ</u>	nd 2 salth ar		Melissa M			r)	401 I	inks	View	Drive.	Hagerst	own.	MD 2174	.0
ē,	Hea Hea tem		20a. Method of Disp		(	20b. I	Place of Dispo	sition (Nan	ne of	-	Date		ocation - City or To	
<u>0</u>	00	i		Tremation 3 ☐ 5 ☐ Other (Specify		ate	sthaver	•		l l	24/2004	Fred	lerick, M	ID.
altimore,	그들은	1	21. Signature of Fur					2. Name an						eral Home
B	permi Depar Impor any ir		1/1-	5. 4	Lat !	4				O.			stown, MD	
26			23a. Part1. Enter th	e disease, or comp	lications that cau	sed the dea						-		Approximate Interval Between
Ų,	Physician		Immediate Cause (		one cause on eac	n line.	1/-17	4 0	1:	1	n:			Onset and Death
44	/Medical		disease or condition resulting in death)	-	a. Due to (or	as a consec	uence of):	ru 04	nie	unis	Proca	5 2		10 yos.
26	Examiner			- 1	Pin	man	2 211	fin	2	inoac	c.			
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oʻ	exec an an rial-tr	Еха	resulting in death) L	ast	Due to (or	as a consec	quence of):							
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89	tifica ng ph as th	Wedlcal												
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Δ.	that the	P.	Part II. Other signifi	icant conditions co	ontributing to dea	th but not res	sulting in the u	inderlying c	ause given	in Part I.	23e. Did	tobacco	use contribute to ti	he cause of death?
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Ö	w requir been si should	Completed									24a. Was	2 20	24h Were auto	oney findings available
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ō	Phys r this ral di	7:	1 Tyes 2 Page 27. Manner of Peath		28a. Date of (Month,		28b. Time o		8c. Injury a Work?	4 🗆 Hursing	28d. Describe		6 ☐Other (Specifing occurred)	<i>y)</i>
o	ding h. Afte fune	tor	1 Natural 2 Accident	5 Pending investigation		Day Year)	Injury	м		s 2 No				
Division of Vital Records,	if or Attending Physician: after death. Director: After this certification by the funeral director.	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place o	Injury - At h , etc. (Speci	iome, farm, sti fy)	reet, factory	r, office		28f. Location City or To		nd Number or Rura e)	Il Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)	Certifying Ph 2 Medical Exam		is of examina								
	To th within Fo th	Me	29b. Signature and	title of certifier		)		290	. License r	number			te signed (Month,	
			> Wa	in Ella	neer 11.			D	238	115		2	-23-0	74/
			30. Name and addre	e of person who	completed cause	of death (Ite	т 23а) (Туре,	Print)				0	21740	
			Mary &	Money	, M 3	54 h	1:11 87	reet,	Ha	serstou	n, mi	1) 2	21740	
			ma m		1 4			11	7					

Registrar

29a. Certifier (Check only one)

31. Date filed (Month Day Year)

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

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**Funeral** 

Director

death with the Maryland

permit Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Importent: If itam 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Plea	ase Type or Pri	int in Black Ir	ndelible Ir	ık. Ens	ure A	All Copies /	Are Leç	aible.	
_ For		laryland / Dep				-	_		7494
1 - State Registrar			ertificate o				eg. No.	07 -	1777
1. Decedent's Name (First, Middle	ile, Last)					2. Date of Death Month	h Dav	Year	Time of Death
	Barbour, Sr.		C': Tow	· · · · · · · · · · · · · · · · · · ·	7	February	/ 16th	2004 7	7:15 AM
4a. Facility Name (If not institution Western Marylar	nd Hospital	Center	Hagers				Washi	ington	
5. Social Security Number 234-01-9916	6. Sex 7. Ag	nge (In yrs. last birthday) 84 Yrs.	y) If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day, ) Feb. 17, 1	Year) 1919	9. Birthplace ( Country) West Virg	(State or Foreign ginia
Usual Residence of Decedent  10a. State 10b. County	v	10c. City, Town or Lo	ocation					10d. lr	nside City Limits
Maryland Was	, shington	,	agerstown					×	XXYes 2 □ No
10e. Street and Number  11 West Baltim	ore Street		10f. Zip Code	2174(	0	100	g. Citizen of	of What Country?	
11. Marital Status	12. Was Decedent Armed Forces?	t Ever in U.S. 13	J. Was Decedent of If Yes, specify Cu			pecify Yes or No-		ace - American Inc	idian,
1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	rried XXYes 2	No WW I	If Yes, specify Cu			Rican, etc.)		lack, White, etc.	
15. Deceden (Specify anty highe:	nt's Education est grade completed)	16a. Dece (Give	edent's Usual Occ re kind of work don DO NOT use reti	cupation ne during mo	st of work	king 1	6b. Kind of F	Business/Industry	
Elementary/Secondary (0-12)	College (1-4or	5+)					+hc	- P-2000	- :
17. Father's Name (First, Middle,	, Last)		Labor		ier's Nam	ne (First, Middle, Ma		er Proces	sing
David Willia	am Barbour			Dais	sy F	Belle Hu	ull		
19a. Informant's Name/Relations	ship (Type, Print)	19b. Maili	ing Address (Stre			ral Route Number, (	City or Town	n, State, Zip Code	э)
Sharon K. Banz	hoff -Daught					ort,Maryl		21795	
20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S)	3 ☐Removal from State	20b. Place of Dispo	position (Name of matory or other p	place)	C	Date 20	20c. Location	msport, M	
21. Signature of Funeral Service	1 7	0 22	22. Name and Add Osborne F	dress of Facilit Funeral	Hom				21795
23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	ed the death. Do not ent	nter the mode of dy	dying, such as	s cardiac o	or respiratory arrest		Appro	roximate rval Between set and Death
dise e or condition resulting in death)	aDue to (or as	s a consequence of):	Kena	l di	'scu	se		22	nonths
Sequentially list conditions,	ь	abelese	me	Mitu	15.			14	ears
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):	Cerosi	s ·				7	leass.
	d	a torracq							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)					ate of delivery lonth Day	Year
Part II. Other significant condition	ons contributing to death b	out not resulting in the u	ınderlying cause ç	given in Part I.			acco use cont	ntribute to the caus	use of death?
Cores	nary are	lery ms	rasc			24a. Was an autopsy	24b.	. Were autopsy fine	ndings available
Chron	e olis Fry	scrive 1	'unga	liseas	2	performe 1 ☐ Yes 2	ed? No	death?	
25. Was case referred to medical examiner?				Other		th (Check only one)			
1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		of 28c. Init	nury at	1	ome 5 Residence			
1 Natural 5 ☐ Pending	ng (Month, Da) igation	ury 28b. Time of ay Year) Injury	W	njury at Vork? □ Yes 2 □ 1		28d. Describe how	injury occur.	red	
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nined 286. Place of Inju	ijury - At home, farm, stretc. (Specify)	reet, factory, offic	е	7	28f. Location (Stree City or Town, S	et and Numb State)	per or Rural Route	e Number,

Priysician /Medical Examiner Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical Medical Certification; To

3H-2+1 State

Certifying Physician: To the best of my knowledge, death Medical Examiner: On the basis of examination and/or invalid manner stated.	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
le of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Lever 2	244996	February 16, 2004

29b. Signature and tit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Hagerstown, MD 21742

MD 32. Registrar's Signature

Registrar

			For State Registrar	State of Ma		ertificate of L			giene 20	04	07495	
-	Physici /Medio	cal	Decedent's Name (First, Middle, Last)     ENOS HENRY     4a. Facility Name (If not institution, give s		RD, SR.	4b. City, Town, or	Location of Deat	2. Date of Dea Month 2	Day	Year 2004 of Death	3. Time of Death 11:40PM	
	Examir	ier	10344 OLd Oce	an City B		Berlin			Worcester			
The second	Funeral Director		174-20-4346	M 2 F 7. Age	(In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 4/14/	7 Year) 1928	9. Birthple Count	mce (State or Foreign my) MD	
	land ow		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10	d. Inside City Limits	
	e Man ta-fsh	ctor	MD Worceste	er	Berli	in					1 XYes 2 No	
	with th	Director	10e. Sfreet and Number  10344 Old	Ocean Cit	v Blvd	10f. Zip Code 21811			10g. Cifizen of V USA	Vhat Count	ry?	
	d within 72 hours after death with the Maryland plan. Jiene. T than "natural; or Itema 23e or 28e-f show the Modical Examinate matter notified at	by Funeral		2. Was Decedent Endemed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rac Blac	e - America k, White, e	tc.	
Maryland 21215-0036	2 hour	ted b	15. Decedent's Educ	ation		edent's Usual Occupa e kind of work done o		rtina	16b. Kind of Bu	siness/Ind	ustry	
	dthin 7 ne. han 'n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	) life.	DO NOT use retired,	) )	king				
מ	it the		17. Father's Name (First, Middle, Last)		Ca	rpenter	18. Mother's Nar	ne (First, Middle,	Constr Maiden Sumam		n	
lan I	d be antal	To Be	Dewey Bradford				Mildre	d Tubbs				
dar)	2 sh and Is m	18	19a. Informant's Name/Relationship (Typ.  Jean Bradford	oe, Print)		ling Address (Street a						
	1 an Heal em 2		20a. Method of Disposition		20b. Place of Disp	position (Name of		Date	20c. Location -			
Ē	0 0 = =		1 ☐XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory or other place de Cemete		25/04	Liberty	town	, MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Fundral Service License	hale		22. Name and Addres The 108 Willi	Burbag am St. I	e Funera Berlin. M	al Home MD 218	11		
	<u> </u>		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused to	he death. Do not e			•			Approximate Inferval Between	
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	C005	)						Onset and Death	
	Examiner			Due to (or as a	consequence of):							
3	5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence or).							
<u>,</u>	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a	consequence of):			·				
9/8	ate be hysicia the bur	dlcal	d									
O. Box 6	death certiti e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐Ectopic pregnancy			23d. Dat	e of deliver	y Day Year	
S, P.(	de de	by Phy	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?	
spic	w requires been sign should be							1 🗆 Y	es 2 🗆 No	3 🗌 Proba	bly 4 Donknown	
	The law ate has b page 2 sl	Completed						24a. Was a autop perfor	med?	rior to com leath?	sy findings available pletion of cause of	
VIta	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Othe	7	th (Check only or				
ō	ding h. Atter tune	ıtlon; To	1 ☐ Yes 2 ☑ No   27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatien 28a. Date of Injury (Month, Day	28b. Time	of 28c. Injury Work	4 🗀 Nursing n	ome 5 Resid	ence 6 Othe			
Division	i Die	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y · At home, farm, s (Specity)	treet, factory, office		28f. Location (S City or Tow	treet and Number, State)	er or Rural	Route Number,	
	Ho: Fur ely	edical (	29a. Certifier (Check only one)	er: On the best of and manner state	examination and/or i	ith occurred at the tim nvestigation, in my op	s, date and place pinion, death occu	, and due to the e rred at the time, o	aus (s) and ma late and place, a	iner as sta ind due to t	tod. the cause(s)	
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	und marrier state		29c. License	number		29d. Date signed	(Month, D	ay, Year)	
	. 220		Lephen ?	Madan	00	HOS	53714		2/2	3/0	9	
Ц	1-		(1)	mpleted sause of dea				4.0	0.11			
	) (j) Sta	ite	31. Date filed (Month, Day, Year)	32. Fiegistrar	's Signature	is an a	811 -	lettry	inniz	7-1E		
	Regist		FEB 2 4 201	34 Binus	J. J. A.	passe						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 1 1 edent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number)

St. Vincent dePaul 4b. City, Town, or Location of Death 4c. County of Death **Examiner Nursing Center** If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birtinplace (State or Foreign Country) Funeral Months Days Hours Min. 1 □ M 2 1 1 F Director 111 October 25, 1924 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 7 is marked other then "natural", or items 23s or 28s-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 15331 Miners Avenue S.W. by Funeral 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ralph Barber Jennie Muir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is 927 Ampere Pl. Lake Saint Louis, MO, 63367 Date 20c. Location - City or Town, State Charlotte Fisher-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Importent: If it any injury or o 1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State February 16, 4 ☐ Donation 5 ☐ Other (Specify) Fckhart Cemetery 2004 Eckhart, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 23a. Plant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as careful by Constructing Md.21539 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician end struce chroni c 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner signed by the attending physician and deed be detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig r, page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No certificate has autopsy 1 Yes 2 X No Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WorsockShini 00055325 ما 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

48 Tarn Terrace
31. Date filed (Marth, Day, Year)
FEB 1 8 2004

nds

MD21532

Frostburg

32 Registrar's Signature

WONSOCK SHIN MD

		1 - Stete Registrar		epartment of Health and Certificate of Death	Reg.	No. 2004	0749
Physicia	an .	1. Decedent's Name (First, Middle, Last	")		Date of Death     Month	Day Year	3. Time of Death
/Medic		Hulda D. Baker			February	19, 2004	2:40 A <sup>M</sup>
Examin	er	4a. Fecility Name (If not institution, give		4b. City, Town, or Location of De	eath	4c. County of Death	
	-	Mariner Health Ca  5. Social Security Number 6. Se			(S. R Date of Righ	Montgome	ry
uneral irector			744 087 5	rs. Months Days Hours M	in. (Month, Day, Ye Nov. 26,	9. Birth Cou 1907 Penn	olace (State or Foreign ntry) sylvania
M III		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
ried fied	į	Maryland Montgomer	y Kensir	ngton			1 ☐ Yes 2 🖔 No
e net	ire	10e. Street and Number		10f. Zip Code	10g.	ntry?	
23a c	ai	9912 Hillridge Dri	ve	20895	Uni	ted State	s
teme 23a or 28a-f ehow at must be mulfied at	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
rthen "natural", or it the Medical Exemp	by Fi	1 Never Married 2 Married 3 Nover Married 2 Married 3 Nover Married 2 Noverced	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: Whi	
al Ex	ed b	15. Decedent's Edu	Year or Dates:	Decedent's Usual Occupation	106		
Sertific C	Completed	(Specify only highest grad	le completed)	(Give kind of work done during most of v life. DO NOT use retired)	vorking	. Kind of Business/In	dustry
other then	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	ler.		nking	
event,	Bec	17. Father's Name (First, Middle, Last)		18. Mother's N	lame (First, Middle, Maid		
matic ev	To B	Carson Young		Sara N	lot Availabl	.e	
E E	-	19a. Informant's Name/Relationship (T)	/pe, Print) 19b.	Mailing Address (Street and Number or	Rural Route Number, Cit	ty or Town, State, Zip	Code)
or tra		Patricia Christian	sen/Daughter 991	2 Hillridge Drive,	Kensington	, MD 2089	5
eny injury or other traumatic er		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F	20b. Place of cemetery	Disposition (Name of r, crematory or other place)		Location - City or To	
ريم		*4 □Donation 5 □Other (Specify)	Edgewoo	od Cemetery 23,	2004		ennsylvan
any inju		21. Signature of Funeral Service Licens	88/1/	22. Name and Address of Facility Ro Rockville, Inc. 3 Rockville, Maryla	bert A. Pun	phrey Fun	eral Home
= = 3		1 JRS	M01346	Rockville, Maryla	nd 20850	tgomery A	venue
sician edical miner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  a. Pneumonia  Due to (or as a consequence o	ot enter the mode of dying, such as card			Approximate Interval Between Onset and Death  Week
he burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of				
physi the t	edica		d				
detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{yes} \) 2 \( \subseteq \text{No} \) 9 \( \subseteq \text{Unknown} \)	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death  4  Pregnant at time of death  9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
deta		Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
ed be	P	Dementia			1 ☐ Yes	2X No 3 Prob	abiy 4  Unknowr
should	iete	Hypertension			24a. Was an	24h Were auto	psy findings available
page 2	Completed by	ny per cension			autopsy performed	prior to cor	impletion of cause of
or, p	Ö .	25. Was case referred to medical		26 Place of D	1 ☐ Yes 2 ፟ ☐ I	No 1 ☐ Yes	2LJ No
director, pag	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	04	Home 5 Residence	6 DOthor (Consider	.ì
the funeral di	ä	27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how in		//
u e fru	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	ury Work? M 1 ☐ Yes 2 ☐ No			
5	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, Sta		l Route Number,
completely filled in by the fu	edicai (	29a. Certifier 1 \(\bigcit{\mathbb{K}}\) Certifying Phy (Check only one) 2 \(\bigcit{\mathbb{M}}\) Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and pla for investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
complet	M	29b. Signature and title of certifie	)	29c. License number	29d. [	Date signed (Month,	Day, Year)
		1		D0053528	Feb	ruary 19,	2004
	1	30. Name an laddess of person who co	ompleted cause of death (Item 23a) (T		reb	ruary 15,	2004

			1 - For State Registrar	State of M	Maryland		artmen <i>rtificat</i>				lental Hy	giene Reg. No.	20	) 4	07491
4	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last     Thomas Edward Bern     As Fecility Name (If not institution, give	ney	ar)		4h C:h:	Tour	Location	of Dasit	2. Date of De Month Februar	nath Day	8, 20	rear 004	3. Time of Death 12:30 PM
	Funeral	ier	Rockville Nursing 5. Social Security Number 6. Se	y Home	Age (In yrs. Ia:	st birthday)	Ro If Under	ckvi 1 Year	11e	24 Hrs.	8. Date of Bin	М	County of	omery	
	Director		361-20-5822	<b>Д</b> М 2□F	75	Yrs.	Months	Days	Hours	Min.	Oct. 5	, 19	28	LILII	
Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene.  Important: if tiem 27 le marked other than "naturel", or items 238 or 28a-f ehow eny injury ocother traumatic event, the Medical Exercities marker rotified at once.	To Be Completed by Funeral Director	Maryland Montgomer  10e. Street and Number  2307 Ring Street  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  James Berney  19a. Informant's Name/Relationship (Ty)  Jean M. Berney/Dau  20a. Method of Disposition  1 Marital 2 Cremation 3 February  21. Signature of Funeral Service Licens	12. Was Deceder Armed Forces 1 157 Yes 2 2 11 Yes, Give Year or Dates Ication 12 College (1-40 4 12 Pe. Print) 12 Shter Removal from State	Rock  Rock  1. Ever in U.S.  1. Place  1. Place  20b. Place  Gate  M01353	16a. Deceding Give life.  Sale  19b. Mailin 12209  Decedor of Disponentary, cran Coff H Cemet 222 Road Ro	208 Was Deceded Yes, spec 1 Yes 2  dent's Usua kind of wor DO NOT us s /Mar  Garage Address  Kend stien (Namatory or oid eaven erv Name anc ckyilckyilckyilckyilckyilckyilckyilckyil	91 Street and (Street and place)  (Address le, )	tion uring most  ng 18. Mother Mary nd Number Stree  of Facility Inc. Mary1	r's Name Russ r or Rura 200 Robert 300 and	ecify Yes or No-Rican, etc.)  ing  e (First, Middle, sell al Route Number Wheaton, late ry 23, 124 Event A. F. 20850	Micr Maiden Maicr Maiden Maiden Maiden Maiden Maiden Maiden	Specify: nd of Busing Cofile Sumame)  Town, Starrylan cation - Cier Sp	at Count  Cates  America White, e  White, ness/Indu  m Equ  ate, Zip C  d 20  y or Tow  ring	e ustry uipment
ec	Physician /Medical physician and physician and physician and the private ransit	licai Examiner	resulting in death)	Muscula Due to (or a  Pancrea Due to (or a  Ascitis	ar Dyst s a consequer atic Ca s a consequer	rophynce of): nce of): nce of):	er the mode	of dying	, such as c	cardiac <i>o</i>	r respiratory arr	rest,		J.	Approximate nterval Between Onset and Death 1.e year
	death certific e attending p ed for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3	Ectopic pre Other (spe					2:	3d. Date o	-	ay Year
	law requires that the as been signed by the 2 should be detached.	by	Part II. Other significant conditions cor	tributing to death	but not resultin	ng in the un	derlying car	use given	in Part I.						cause of death?
ב ן	20 22 00	e Completed	25. Was case referred to medical								24a. Was a autops perform	iy ned? 2∭ No	deat	e autops to comp h? Yes 2[	y findings available letion of cause of
10121	to the Tropical or water the within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ToB	examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Outpatient b. Time of Injury a, farm, stre	286 M	Other c. Injury a Work? 1  Ye	4 <b>X</b> ] Nurs	sing Hom 2	(Check only on the 5 Theside 8d. Describe ho 8f. Location (St. City or Town	ence 6 bw injury	occurred		Route Number,		
4 :	within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner st	or examination	dge, death and/or inve	occurred at estigation, in	the time	, date and nion, death	place, ar	nd due to the ca	ause(s) a ate and p	nd manne blace, and	r as state due to th	ed. e cause(s)
	THI BOT IN		29b. Signature and title of certifier  Wown		Posep		D 4	License r					signed (M		
	Sta Registra	te	30. Name and address of person who con Thomas Joseph, M.D.  31. Date filed (Month, Day, Year)	., 50 Wes		onstor	Dr.	#207		ckvi	lle, Ma	ryla	nd 20	)852	

			1 - State MEND#5perINF3/8 Registre/MEND#14perINF	State of Man 3/04, BW, McCo	yland / De	partment ertificate	of H	ealth a Death	and M	lental Hyg	iene 2	004	07	499
	Physici		Decedent's Name (First, Middle, La	st)	<del>~~</del>					2. Date of Deat Month	h Day	Year	3. Time o	f Death
	/Medic			oiragee						Februar	y 18,	2004	5:17	а м
	Examin	er	4a. Fecility Name (If not institution, giv			4b. City, T						unty of Death		
	Funeral		Holy Cross Ho		n yrs. last birthd	ay) If Under 1	Year	r Spr	24 Hrs.	8. Date of Birth		ntgome 9. Birth	place (State	or Foreign
	Funeral Director		5. Social Security Number 2.19-11-505.7	1⊠M 2□F	4 Yrs	Months	Days	Hours	Min.	(Month, Day, Dec. 4.		Cou	ntry)	
	B >		Usuel Residence of Decedent  10a. State 10b. County		Oc. City, Town or	Logation					*****		10d. Inside C	in Limita
	shov	'n			,									2 ☑ No
	28s-f	Directo	Maryland Montgo	mery	Silve	r Sprin				1	0a. Citizen	of What Cou	ntry?	
	3e or	0	8662 Dinor Propo	h Dood Ant	104	209					US			
	deeth	Funeral	8662 Piney Branc  11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1			spanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)	14.1	Race - Ameri		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show amy injury or other traumatic event, the Madical Examinal must be notilised all once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Yes 2		Specify:	, , , , ,	1110211, 010.7	As Spe	Black, White SIAN II Paile Whi	ndian te	
21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gra			cedent's Usual			t of work	ina	16b. Kind o	of Business/Ir	ndustry	
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	\iii	e. DO NOT use	retired)	uning most	OF BOIL	,,,,,				
2	ygien ygien her th			2	M	inister	1	40 14-11-	4- 11	- (First 1874)		igion		
and	ntal H nd ott	Be	17. Father's Name (First, Middle, Last							e (First, Middle, A	Maiden Sun	name)		
Ž	hould d Me mark matic	은	Priyo Nath Boir 19a. Informant's Name/Relationship (	-	19b. M	ailing Address /	Street a			a Majhi al Route Number,	City or To	wn. State. Zi	n Code)	
Z Z	ulth ar 27 is r trau		Samar Boiragee/	**						Takoma P	-			
ře,	Stan He a		20a. Method of Disposition		20b. Place of Di		g of			Date		on - City or T		
Ë	Page nent o nnt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		Gate of			F		uary 20 004	flver	Spri	na. MD	
Baltimore, Maryland	prmit.		21. Signature of Funeral Service Lice	nsee		22. Name and	Address	~ 44		_	CATALON CONTRACT	V		
-	20129	110	Hallas SE	) celes (		500 Uni	vers	ity	Blvd	Funeral W., Si	lver	Sprin	MD	20901
	Physician /Medical		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cerebrov	ascular			, such as	cardiac	or respiratory arre	est,		Interval Be Onset and	tween
4	Examiner			Due to (or as a c		Cardio		1.~~	Dia					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	vasc	ular	DIS	ease							
8760,	death certificate be executed e attending physician and and for use as the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
9	ertification plants pla	Med	IF FEMALE:	000 16 100 0140000 04								1		
P.O. Box	that the death certific ed by the attending p detached for use as	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetel death	3 □Ectopic prec 5 □ Other (spec					23d.	Date of delive Month	•	Year
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cau	use give	n in Part I.		23e. Did tob	acco use c	contribute to t	he cause of	death?
rds	w requires been sign should be	q pa	Chronic Renal Fai	lure/ Dialy	sis Dep	endent,				1 □ Ye	s 2 🙀 No	o 3 ☐ Prot	oably 4 🗆	Unknown
of Vital Records,	law requ as been 2 shouk	Completed	Congestive Heart	Failure.						24a. Was ar		b. Were auto	psy findings	available
m m	The lay ate has page 2	mo;	Coronary Artery D	•	te Myog	ordiol I	Info	rotio		autops perform 1 Yes 2	red?	death?	2□ No	ause of
ita	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?		ec myoca	itutat	-	26. Place	of Death	(Check only one	9)			
5	physic this o	2	1 ☐ Yes 2 ☑ No		2 ☑ ER/Outpa					me 5 Reside			fy)	
UC C	ding F	lon:	27. Manner of Death 1 ⊠ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yo	ear) 28b. Time Injur	y M	c. Injury Work	at ? es 2.⊟h		28d. Describe ho	w injury oc	curred		
Division	or Attending Physician: after death. Director: After this certific: in by the funeral director.	Certification;	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	8 29a Place of Injune	- At home, farm, Specify)		_	63 20.		28f. Location (Str City or Town		ımber or Rum	al Route Nun	nber,
_	Hospitel 4 hours a Funerel iely filled	Medical Ce	29a. Certifier 1 X Certifying Pr (Check only one) 2 Medical Exam	nysicien: To the best of m miner: On the basis of ex and manner stated	amination and/or	eath occurred at investigation, in	t the time	e, date and inion, deat	d place, th occurr	and due to the ca	use(s) and ite and plac	manner as s	stated. the cause(	5)
	To the within 2 To the complet	Me	29b. Signature and title certifier	1		29c.	License	number		29	d. Date sig	gned (Month,	Dey, Year)	
}	2		1/6	_			1) 4	1867			Febri	iary 18	8, 200	4
-			30. Name and address of person who	completed cause of deat	h (Item 23a) (Typ									
				UNZY	LUNGA	MD	7/0	IKA	Ndo	lph Rd	Ko	Kuille	MUZ	-0852
-	Sta	te	31. Date filed (Mornth, Day, Year)	32. Registrar's	Signature	Som	Ka	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07500 State of Maryland / Department of Health and Mental Hygiene 2004 State
Registra/MEND#26perMD2/26/04, MW, McCo Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 8:25 PM February 20, 2004 Doris Lorraine Brant 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Clayton Comfort Care Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours 1 ☐ M 2 🖾 F Yrs. 87 21, 1916 Dec. Maryland 577-03-0518 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Maryland Montgomery Wheaton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 12802 Matey Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 🖾 No Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 County Government Crossing Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jesse Franklin Riley Grace Hoffman Huyett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8009 Crabtree Place, Gaithersburg, MD 20879

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

February 23, 2004

28d. Describe how injury occurred

the Maryland s 23a or 28a-f show death or Itams filed within 72 hours after Baltimore, Maryland 21215-0036 natural than Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 is marked other? Department of Health and Menta Hygi Important: If Item 27 is marked other any injury ocother traumatic event, once. permit.

**Physician** 

/Medical

Examiner

Direct

۵

Completed

Be

George K. Brant, Jr./ Son

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 🗀 Homicide

29b. Signature and little of cert

Nakul Goyal M.D.

31. Date filed (Month, Day, Year)

5 Pending

FEB 26 2004

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3801

6 Could not be

**Funeral** 

Director

**Physician** /Medical Examiner

Physician/Medical Examiner use as the burial-transit ò detached signed b Be Completed by page 2 should rector. Certification: To After To the Hospitel or Attandir within 24 hours after death. To the Funerat Director: A in by t

Division of Vital Records, P.O. Box 68760,

or Attanding Physician:

filled

Medical

State

Registrar

20a. Method of Disposition	□Comount from State	20b. Place of Disposition (Name of cametery, crematory or other plat Arlington National	Pebruary 2		cation - City o	r Town, State
'4 □Donation 5 □Other (Spec		Ariington Nationa Cemetery	2004		ngton,	Virginia
21. Signature of Funeral Service Lice  23a. Pent 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	molecations that caused t	500 Univer	Collins Funer sity Blvd. W.,	Silve	e Inc. r Spri	Approximate Interval Between Onset and Death
disease or condition resulting in death)  Sequentially list conditions,		consequence of): ascular Disease				Days
sequentially lacelliness, fam,	Oue to (or se s	consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3 Ectopic pregnancy		_ 2	3d. Date of de Month	olivery Day Year
Part II. Other significant conditions	contributing to death but	not resulting in the underlying cause giv		id tobacco u □ Yes 25		o the cause of death? robably 4 \(\sum \text{Unknown}\)
			p	/as an utopsy erformed? s 2⊠No	death?	utopsy findings available completion of cause of s 2 No
25. Was case referred to medical examiner?		- 11/11/2	26. Place of Death (Check or	ly one)		
1 ☐ Yes 2 ⊊ No	Hospital: 1 Inpatient	t 2 ER/Outpatient 3 DOA	er: 4 ☐ Nursing Home 6 □ □	esidence 6	Other (Spe	city) Hospice

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

10

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D38457

International Drive, #211, Silver Spring, MD 20906

racks

1 ☐ Yes 2 ☐ No